Proactive Podiatry

Dr. Latika Hinduja
3578 Brodhead Rd. Monaca, Pa 15061
Phone: 724.775.6168 Fax: 724.775.2633

Today's Date: ____/____/____ Patient Chart Number: _____

Patient Name: _____ Age: _____

What is bringing you in to see the doctor today?_____

_____

General Health

Height: _____ Weight: _____lbs. Shoe Size: _____

Self	Family		Self	Family	
		Arthritis			Tuberculosis
		Mitral Valve Prolapse (Heart Murmur)			Cardiac Disease
		Scarlet Fever			Breathing Problems (explain: _____)
		Hypertension (High Blood Pressure)			Venereal Disease
		Peripheral Vascular Disease (Circulation)			Hemophilia (Bleeder)
		Gout			Stomach Problems
		Cerebral Accident (Stroke)			Renal/Kidney Disease
		Diabetes (Type: _____)			Polio
		Liver Disease			Cerebral Palsy
		HIV Positive (AIDS)			Muscular Dystrophy
		Blood Transfusion (when?_____)			Phlebitis/Thrombophlebitis (Clot)
		MRSA			Anemia (Blood Disorder)
		Thyroid Disease			Slow Healer
Other:					

Surgical History:
Please list ALL surgical intervention.

_____

_____

_____

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Personal History:

Tobacco Use: YES or NO	How often? Daily Socially Rarely	How Long? (years)
Alcohol Use: YES or NO	How often? Daily Socially Rarely	How Long? (years)
Recreational Drug Use: YES or NO	How often? Daily Socially Rarely	Name of Drug:

Are you taking any medications? YES or NO
If yes, please list below: (or provide us with a copy of list)
(Please include your prescription medication, vitamins, birth control pills, herbs, and any over the counter medications)

Allergies and Reactions:

Penicillin	Tetracycline	Aspirin	Foods (Please specify)	Adhesives
Sulfa Drugs	Novocain	Codeine	Caffeine	Other:
Barbiturates	Cortisone	Iodine Dyes	Enviromental (Please specify)	

Consent for Treatment

The above information is correct to the best of my knowledge and consent to such diagnosis procedures (including x-rays) and medical care and treatment as deemed necessary by Dr. Latika Hinduja.

Signature of Patient or Guardian:

_____ Date: _____

Signature of Witness:

_____ Date: _____

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Sex: MALE or FEMALE Birth Date: _____ Marital Status SINGLE MARRIED WIDOW DIVORCE

Social Security Number: _____-_____-_____

Home Address: _____

City: _____ State: _____ Zip Code: _____

Email Address: _____

Home Phone Number: _____ Cell Phone Number: _____

If the patient is a minor, please give the name of parent or guardian who is financially responsible for billing.

Name of spouse/parent: _____ Birth Date: _____

Spouse's/Parent's Employer: _____

Employer Address: _____

City: _____ State: _____ Zip Code: _____

Employer Phone Number: _____ EXT: _____

Patient's occupation: _____

Patient's employer: _____

Employer's address: _____

City: _____ State: _____ Zip Code: _____

Employer Phone Number: _____ EXT: _____

Other Information

Primary Care Physician (PCP): _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone Number: _____

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Have you ever received DME: YES or NO
(Walking Boot, Braces, Crutches, Cane, Walker, Shoes, and/or Orthotics)

Primary Pharmacy Name: _____

City: _____ State: _____ Zip Code: _____

In case of EMERGENCY contact

Name: _____ Relationship: _____

Home Phone Number: _____ Cell Phone Number: _____

Discussion of Medical Information

List any individuals with whom we may discuss your medical care and diagnosis. (Please provide **their** birthday for them to have access to any confidential information)

Name: _____ Relationship: _____

Phone Number: _____ Birth Date: _____

Name: _____ Relationship: _____

Phone Number: _____ Birth Date: _____

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Acknowledgement of Receipt of

Notice of Privacy Practices

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read, if I so choose) and understand the notice.

Assignment of Benefits

THE FOLLOWING IS REQUIRED BY LAW:
PLEASE READ CAREFULLY AND SIGN

I request and authorize **Dr. Latika Hinduja** to release any information to the Health Care Financing Administration, Medical Assistance and my insurance company required to process my healthcare claim for services rendered by **Dr. Latika Hinduja**. I understand my signature authorizes **Dr. Latika Hinduja** and staff to examine and treat me, including x-rays. I also understand payment for services or items could be for federal and/or state laws.

I hereby request payment be made directly to **Dr. Latika Hinduja**, by authorizing Medicare, Medical Assistance, and/or all other insurance companies for all services rendered to me through **Dr. Latika Hinduja**. I understand that I am personally responsible for all charges which Medicare, Medical Assistance, and/or any other insurance company may or may not pay, including but not limited to co-insurance, co-payments, deductibles, and non-covered services. I agree to make payment in full within 30 days of receipt of billing. Aged account balances may be forwarded for collection with additional fees being incurred. Finally, I understand and agree this authorization will remain in effect until the time I request, in writing, termination of this authorization.

NOTICE: If you receive podiatric care by another physician within the past 61 days, MEDICARE may not pay for these services, and you will be responsible.

Signature:	Date:

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NO SHOW FEES POLICY

WE DO UNDERSTAND THAT THINGS CAN HAPPEN UNEXPECTEDLY, AND SOMETIMES WE NEED TO CANCEL A SCHEDULED APPOINTMENT.

PLEASE BE COURTEOUS AND GIVE US A CALL TO LET US KNOW THAT YOU WILL NOT BE ABLE TO MAKE IT. WE WILL BE MORE THEN HAPPY TO RESCHEDULE YOUR APPOINTMENT.

IN THE EVENT THAT A NO CALL, NO SHOW IS MADE, YOU WILL BE CHARGED A NO SHOW FEE OF $50.00.

THIS IS SOMETHING THAT WE DO NOT LIKE TO DO, BUT IT IS NEEDED IN ORDER TO SCHEDULE OTHER APPOINTMENTS NEEDED OR AN EMERGENCY IN YOUR PLACE.

WE THANK YOU KINDLY FOR UNDERSTANDING.

SIGNATURE_____DATE_____

PRINT NAME_____