

PATIENT INFORMATION

Please complete this form on your computer, print and bring to your appointment. OR, you may print and complete manually.



Thank you for choosing Highpoint Foot & Ankle Center. In order to serve you promptly, we need the following information. Please type or print. All information will be confidential.

Date: _____ Cell Phone: _____ Home Phone: _____ Work Phone: _____

Patient Name: _____ Email Address: _____

SSN: _____ Birthdate: _____ Male Female

Address: _____ City: _____ State: ____ Zip: _____

Marital Status: Married Single Divorced Widowed

Primary Care Physician: _____

Address: _____ City: _____ State: ____ Zip: _____

Phone Number: _____ Date of Last Visit: _____

Referred By: _____ Pharmacy Name: _____ Pharmacy Phone: _____

RESPONSIBLE PARTY

Name of person responsible for patient (if other than yourself): _____

Relationship to Patient: _____

INSURANCE INFORMATION

Name of Insured: _____

Birthdate: _____ SSN: _____ Relationship to patient: _____

Name of Employer: _____ ID#: _____

Insurance Company: _____ Group#: _____

Insurance Company Address: _____

City: _____ State: ____ Zip: _____

Do you have additional insurance? Yes No

Name of Insured: _____

Birthdate: _____ SSN: _____ Relationship to Patient: _____

Name of Employer: _____ ID#: _____

Insurance Company: _____ Group#: _____

Insurance Company Address: _____

City: _____ State: ____ Zip: _____

AUTHORIZATION & RELEASE

I authorize the release of any information concerning my (or my child's) healthcare, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits.

X _____ Date: _____

Signature of Patient (or parent, if minor)

1500 Horizon Dr., Ste 106
Chalfont, PA 18914
215.997.FOOT (3668)

700 W. State St.
Doylestown, PA 18901
215.348.4397

214 E. Pennsylvania Ave.
Oreland, PA 19075
215.572.6070

444 N. York Rd. Ste. A1
Hatboro, PA 19040
215.672.2111

PATIENT HISTORY

Please complete this form on your computer, print and bring to your appointment. OR, you may print and complete manually.



Name: _____ Reason for today's visit: _____

Do you or any member of your family have any of the following:
Please select yes or no and indicate self or family member for any yes responses.

Diabetes	Yes	No	Self	Family Member
High Blood Pressure	Yes	No	Self	Family Member
Gout	Yes	No	Self	Family Member
Coronary Artery Disease	Yes	No	Self	Family Member
Kidney Problems	Yes	No	Self	Family Member
Liver Disease	Yes	No	Self	Family Member
Arthritis	Yes	No	Self	Family Member
Vascular Disease	Yes	No	Self	Family Member
Ulcers	Yes	No	Self	Family Member
Blood Disease	Yes	No	Self	Family Member
Nerve Disorder	Yes	No	Self	Family Member
Thyroid Disease	Yes	No	Self	Family Member
Other:	Yes	No	Self	Family Member
Please describe:				

Are you on any antiocoagulant medication? Yes No

Are you on any medication including vitamins or herbs? Yes No
 If yes, what are they?

Have you had any surgery? Yes No
 If yes, please explain:

Do you have any allergies to the following?

Latex	Yes	No	Tape	Yes	No
Aspirin	Yes	No	Steroids	Yes	No
Penicillin	Yes	No	Other:	Yes	No
Local Anesthesia	Yes	No	Please describe:		
Iodine (Shellfish)	Yes	No			
Codeine	Yes	No			
Sulfa	Yes	No			

Do you smoke? Yes No How much? cigarettes per day

Do you drink alcohol? Yes No How much? drinks per week

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CANCELLATION & NO-SHOW POLICY

Please complete this form on your computer, print and bring to your appointment. OR, you may print and complete manually.



The following are Highpoint Foot & Ankle Center’s policies regarding cancellations and no-shows:

We take this subject seriously at our office, because it can make the difference between whether you succeed in services received by our office. Showing up as scheduled is one of your more important responsibilities.

In the event of a cancellation, we require a phone call within 24 hours of your scheduled visit time. It is your responsibility to call in. Also, be sure to have an alternative time in mind to reschedule your appointment.

There is a \$20 charge for a cancellation without 24 hours notice and/or for not showing for a scheduled visit. This charge will not be covered by your insurance company, but will have to be paid by you personally.

When a patient does not show up for their scheduled appointment, three people lose:

You, the patient, because you are not getting the needed treatment.

The doctor, who now has an empty space in their schedule since that time was reserved for you personally.

Another patient who could have been scheduled to receive treatment if there had been proper notice.

Please cooperate with us in this regard. We look forward to working with you.

I have read the above policy regarding cancellations/no-shows and understand my responsibilities.

Patient Name (Please Print)

X _____ Date: _____
Signature of Patient (or parent, if minor)

PRIVACY PRACTICES

Please complete this form on your computer, print and bring to your appointment. OR, you may print and complete manually.



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 chose) and understood the Notice.

Patient Name (Please Print)

Parent or Authorized Representative (if applicable)

X _____ Date: _____
Signature of Patient (or parent, if minor)

FINANCIAL POLICY

Please complete this form on your computer, print and bring to your appointment. OR, you may print and complete manually.



Acknowledgement of Financial Policy

Please be advised that you, the patient, are responsible for any procedures or office visits that are not covered by the insurance company.

We will submit all office visits and procedures to participating insurance companies. Certain procedures do need authorization. Please be aware that authorization does not guarantee payment.

I have read the above policy and I am aware that I am responsible for paying any balance on my account in a timely manner. Accounts that are not paid within 90 days may be sent to a collection agency. There will be a 15% charge added to your account for any collection or legal fees.

Patient Name (Please Print)

X _____ Date: _____
Signature of Patient (or parent, if minor)

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MEDICARE PATIENT INFORMATION

Please complete this form on your computer, print and bring to your appointment. OR, you may print and complete manually.



Name as it appears on your Medicare Card: _____

Medicare #: _____

Please sign below so we have your Medicare authorization on file:

I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or the party who accepts assignment. Medicare assignment of benefits regulations apply.

Patient Name (Please Print)

X _____ Date: _____
Signature

SUPPLEMENTAL INSURANCE

Policy #: _____ Group #: _____

Please sign so we have your supplemental insurance authorization on file:

I request authorized MEDIGAP benefits be made on my behalf for any services furnished to me. I authorize any holder of medical information to release to the above MEDIGAP carrier any information needed to determine these benefits or the benefits payable for related services.

X _____ Date: _____
Signature