Harford Lower Extremity Specialists
437 South Main Street, Bel Air, Maryland 21014
Phone: 410-836-0131 Fax: 410-836-8594
www.hlsfootcare.com

Patient ID#_____

Welcome to our office

The following information is needed for proper billing and correspondence.
Should this information change, please notify the office.
If you have any questions, or difficulty completing this form, please feel free to ask for help.

Please print legibly and use black or navy blue ink.

Name				Social Security #
Address				Cell Phone #
City	State			Zip
Home Phone #	Preferred contact (*circle*) Home Cell Work Email *Text			
Date of Birth	Sex	M	F	Marital Status (*circle one*) S M W D Separated
E-mail				
Patient's Employer				Work Phone #
Spouse's Name				Work Phone #
Referred By				

PERSON RESPONSIBLE FOR BILL
(*IF OTHER THAN ABOVE*)

Name	Relationship
Address	
Home Phone	Work Phone

NEAREST RELATIVE TO NOTIFY IN AN EMERGENCY

Name	Relationship
Home Phone	Work Phone

AUTHORIZATIONS

Benefits to the Physician's office:

( ) YES ( ) NO, I hereby authorize payments directly to the physician of the medical/surgical benefits.

( ) YES ( ) NO, I also understand I am responsible for any portion of my bill not covered by my insurance Patient balances are due in 30 days. Interest will accrue at 1.5% on accounts over 60 days with no payment arrangements. Delinquent accounts are sent to collections and have adverse affects on credit history. Insufficient fund checks will be recovered by Re$ubmitit. **THERE ARE NO REFUNDS ON CUSTOM or OVER THE COUNTER PRODUCTS. CREDIT CARD REFUNDS MUST BE IN PERSON.**

( ) YES ( ) NO, I hereby authorize release of information for insurance claim purposes.

MISSED APPOINTMENTS HURT YOU, THE DOCTOR AND SOMEONE IN NEED OF CARE.
MISSED APPOINTMENTS WITHOUT 24 HOUR NOTIFICATION WILL BE ASSESSED:
NEW PATIENTS $75.00, CURRENT PATIENTS $50.00.

*** you must understand that text authorization may incur a landline fee to your phone***

I understand all of the above and hereby state that the information is correct to the best of my knowledge.

Signature	Date
Witness:	Date

Check one that applies: Patient ID#_____

RACE							
	Caucasian		African American		American Indian		Asian
	Latin American		No Response		Other:		
ETHNICITY							
	American		German		African		Mexican
	Italian		Chinese		No Response	Other:	
PREFERRED LANGUAGE							
	English		Spanish		French		German
	No Response		Other:				

MEDICAL HISTORY	
Primary Care Physician	Office phone #
Address	Has he/she referred you to us?
2. List all medications you now use, include over-the-counter, vitamins etc. **Height _____ Weight _____**	
3. **Pharmacy name:**	City/Street:
4. Women: are you pregnant?	If so, how many months?

5. Indicate **immediate RELATIVES** that have/had any of the following diseases such as:
Mother, Father, Paternal Grandparents, Maternal Grandparents, Brother, Sister, Aunt and Uncle.

Arthritis		High blood pressure	
Bleeding disorder		Kidney disease	
Cancer		Mental/emotional disease	
Diabetes		Neurological disorder	
Foot problems		Poor circulation	
Heart disease		Stroke	

6. Do you have any artificial joints, implants, or stents? ( ) no ( ) yes If yes, please explain _____

_____

7. Have you previously had physical therapy? ( ) no ( ) yes If yes, when and for what condition?

_____

8. Is this injury a result of an automobile accident or a worker's compensation claim? ( ) no ( ) yes
If yes, please provide the following information: Claim # _____

Contact _____ Phone # _____

9. Please Check which ones apply to you, for multiply options circle one: Patient ID#_____

MEDICAL ILLNESSES					
Yes	**No**		**Yes**	**No**	
		Anemia			Hormonal Imbalance
		Arthritis			Joint pain or stiffness
		Asthma			Kidney Stones
		Back pain			Liver (jaundice)
		Bladder problems			Lung (pneumonia, TB, etc.)
		Bleeding tendency			Mitral valve, prolapsed/murmur
		Cancer			Neurological disorder
		Chest pain/heart attack			Numbness in feet or legs
		Circulation problems			Osteoporosis
		Cramps in feet or legs			Parkinson's
		Depression / Psychiatric care			Problem taking aspirin/Motrin
		Diabetes			Raynaud's disease
		Fibromyalgia			Scarring tendency
		Gall bladder			Shortness of breath (wheezing)
		GERD			Skin disorders
		Heart (CHF, bypass, etc.)			Strokes
		Hearing impaired			Swelling in feet or ankles
		High blood pressure			Ulcer's (leg, stomach)
		Hypothyroidism (thyroid)			Varicose veins
		HIV positive or carrier			Vision impairment

Other illnesses not listed above:

ALLERGIES

List ALL medications allergies and reactions:

Allergic reaction to latex **YES** **NO**

Allergic reaction to nickel **YES** **NO**

SOCIAL HISTORY

	Do you smoke?		Do you exercise? How much?
	Drink alcohol?		Do you stand or sit at work?
	Do you take drugs?		

SURGERIES

Procedure Name	Date	Doctor	Facility

Patient ID#_____

PF-2000 Acknowledgment of Receipt of Notice of Privacy Practices

Harford Lower Extremity Specialists reserves the right to modify the privacy practices outlined in the notice.

- I have been given the option to receive or downloaded a copy of the Notice of Privacy Practices for **Harford Lower Extremity Specialists** from the Practice website (http://hlsfootcare.com/new_patient.html).
- Please **do not** use my information for fund raising purposes
- I understand that honest and complete answers to each question asked in this medical history
- Questionnaire is important to the provision of my medical care. I have answered them to the best of my ability. I assume all risks which occur as a result of my failure or refusal to disclose all medical information. I understand that if I am uncertain about any questions. I should ask the doctor or a member of the office staff for assistance
- I, _____ have received a copy of the Financial Policy. I further understand that my signature signifies that I accept the terms as set forth in this program.

Signature:_____ Date:_____

- Please identify anyone to whom you grant personal data and information about your care to be released to: (If you have a POA, please list here)

Name: _____ Relationship: _____

Reference for Harford Lower Extremity Specialists Only

Forms/Logs Cross Reference

PFL-2000