Welcome to our Office!

SOUTHERN DELAWARE FOOT & ANKLE

543 N. Shipley St.
Suite C
Seaford, DE 19973
Phone: 302-629-3000
Fax: 302-629-3080

8857 Riverside Dr.
Seaford, DE 19973
Phone: 302-629-6162
Fax: 302-628-3161

28253 Dupont Blvd.
Suite 2
Millsboro, DE 19966
Phone: 302-934-7100
Fax: 302-934-7110

26744 John J. Williams
Hwy. Suite 8
Millsboro, DE 19966
Phone: 302-945-1221
Fax: 302-945-6562

***Attention*: Please fill out all forms COMPLETELY, write N/A where applicable and sign,**

First Name: ______________________ **Last Name:** ______________________ **Middle Initial:** ________

Date of Birth: (MM/DD/YYYY) _____ / _____ / _________ **Age:** _____ **Gender:** ☐ **Male** ☐ **Female** **Marital Status:** ☐ **Single** ☐ **Married** ☐ **Other**

SS#: ______________________

E-Mail Address: ______________________

Address: ______________________ **Apt.#:** _____ **City:** ______________ **State:** _____ **Zip:** ________

Home Phone: (______) ______________ **Work Phone:** (______) ______________ **Cell Phone:** (______) ______________

Employer Name: **Employer's Address / City / State / Zip**

Referring Doctor:	**Address / City / State / Zip**
Primary Care Physician:	**Address / City / State / Zip**
Pharmacy:	**Address / City / State / Zip**

PRIMARY Insurance Co: ______________	**SECONDARY Insurance Co:** ______________
Policy Holder First/Last Name and DOB:	**Policy Holder First/Last Name and DOB:**
Do you have a Co-pay? ☐**No** ☐**Yes, Amount $**	**Do you have a Co-pay?** ☐**No** ☐**Yes, Amount $**
Referral Required? ☐**No** ☐**Yes**	**Referral Required?** ☐**No** ☐**Yes**

Emergency Contact

Name:	Relationship:	Phone #:	Please check box if you give consent for us to speak with this person about your general medical condition/diagnosis/treatment.
			☐
			☐
			☐

Please check the box if we have permission to leave a message on your ☐ **Home Phone** and/or ☐ **Cell Phone** with information pertaining to appointments, labs, x-ray results, or other health care information.

Payments: Patients are responsible for all fees including missed visits and returned checks. Interest and late fees may apply on past due balances. Payment is expected at the time services are rendered any exceptions must be arranged prior to treatment. I hereby consent and give my permission to the doctor (and the doctor's assistants or designated replacement) to provide podiatric services, and medicines, submit my insurance form, consider my signature "on file" for payment, and to release any & all records needed as well as assign all payments to the doctor. I understand the privacy policy and have read and understand the above and agree to be personally responsible for all charges & fees.

☐ **I have received the Confidentially Agreement (HIPAA) and agree to comply with all its terms.**

______________________________ ______________________
Signature of Patient, Parent, Guardian, or Personal Representative Date

SOUTHERN DELAWARE FOOT & ANKLE

Name: ______________________________

Height: _____ Weight (lbs) : _____ Shoe Size: _____

Personal Medical History

__ Abnormal Bleeding
__ Anemia
__ Angina
__ Anxiety
__ Asthma
__ Atrial Fibrillation
__ Back Problems _________________
__ Bipolar Disorder
__ Blood Clots/DVT/PE
__ Cancer (Specify Type and Date: __________)
__ Cirrhosis of Liver
__ Congestive Heart Failure
__ COPD
__ Coronary Artery Disease (CAD)
__ Dementia
__ Depression
__ Diabetes: Type 1 or Type 2
Recent: HbA1c ________
__ Disability: Developmental or Intellectual
__ Fibromyalgia
__ GERD
__ Gout
__ Heart Attack
__ Heart Murmur
__ Hepatitis Type: ______
__ High Blood Pressure
__ High Cholesterol
__ HIV/AIDS
__ Irregular Heartbeat
__ Kidney Disease
Indicate Stage or if on Dialysis: ______
__ Liver Disease
__ MRSA
__ Obesity
__ Osteoporosis
__ Peripheral Neuropathy
__ Peripheral Vascular Disease (Poor Circulation)
__ Seizures
__ Skin Condition (Specify: _____________)
__ Sleep Apnea
__ Stroke
__ Thyroid Disease ___ Hyper ___ Hypo
__ Tuberculosis
__ Vitamin D deficiency
OTHER: ______________________________
____

Social History

Occupation: ____________________
☐ Pregnant ☐ Breast Feeding
Alcohol Use:
☐ Current
☐ Past
☐ Never
Drinks per wk: ___________
Tobacco Use: Including Smoking/Vaping:
☐ Current
☐ Past (Year Quit _____)
☐ Never
Packs per day: ___________
Illicit Drug/Substance Abuse:
☐ Current ☐ Past ☐ Never
Specify Drug: __________

Allergies

☐ No Known Drug Allergies
☐ Adhesive/Tape
☐ Iodine/IV Contrast Dye
☐ Latex
☐ Penicillin
☐ Sulfa
☐ Metals (Specify: ________)

Family History

List Medical Problems:
Mother:
☐ Living
☐ Deceased
Father:
☐ Living
☐ Deceased

Medications

☐ No Medications ☐ List of Medications is attached

Medication	Dosage	How Often

Prior Surgeries

___ Foot/Ankle Surgery (Specify Type of Surgery and Date)
____
____
___ Appendectomy
___ Cholecystectomy (Gall Bladder)
___ Bariatric Surgery __LAP Band ___Gastric Sleeve ___ Gastric Bypass
___ Back Surgery
___ Cataracts
___ Carpal Tunnel
___ Cardiac Surgery: ____ Stents _____ Bypass
___ Hernia
___ Hip Replacement
___ Hysterectomy
___ Knee Replacement
___ Mastectomy
___ Tonsils and Adenoids
___ Vascular Surgery: (Specify: __________________)
OTHER: ____

Reason for Today's Visit: ____
How long have you had this problem: _____________________________________
Any Prior Treatments/Medications/Imaging? _________________________________
What aggravates your condition? ____
What improves the condition? ____

Name________________ Date______________

Do I Need a Test For PAD?

Peripheral Artery Disease (PAD) is a serious circulatory problem in which the blood vessels that carry blood to your arms, legs, brain and kidneys, become narrowed or clogged. It affects approximately 20 million Americans, most over the age of 50. It may result in leg discomfort with walking, poor healing of leg sores/ulcers, blood pressure that is difficult to control, or symptoms of stroke. People with PAD are at significantly higher risk of stroke and heart attack. Answers to these questions will help determine if you are at risk for PAD and if a vascular exam will help us better assess your vascular health status.

Check All Applicable Boxes

1. Do you have foot, calf, buttock, hip or thigh discomfort (aching, fatigue, tingling, cramping or pain) when you walk which is relieved by rest? ☐
2. Do you have a history of cardiovascular disease or diabetes and experience any pain or swelling at rest in your lower legs or feet? ☐
3. Do you have a history of cardiovascular disease or diabetes and experience any leg, foot, or toe pain that often disturbs your sleep? ☐
4. Do you have an ulcer on your thigh, calf, ankle, foot or toe that is slow to heal? ☐
5. Do you have diabetes and unusual hair loss or skin discoloration in your legs? ☐
6. Do your fingers or toes feel numb or cold in response to temperature changes or stress? ☐
7. Have you suffered a severe injury to your leg(s) or feet? ☐
8. Do you have an infection of the leg(s) or feet that may be gangrenous (black skin tissue)? ☐
9. Have you had blockages in your coronary or heart arteries? ☐

Other Comments or Notes: ____

____

____

Patient Signature:______________________________ Date:______________

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This information is for illustrative purposes only. All claims should be reviewed and/or processed by a billing expert prior to submission as insurance claim policies and procedures are subject to change at any time without notice.

Southern Delaware Foot & Ankle Financial Policies

Most of you are aware that healthcare is vastly different today than years ago. Insurance premiums are higher and costs have shifted to you, the patient. In an effort to keep up with the ever-changing industry a few policies will be implemented. Patient name: ___________________________

1. All patients **MUST** settle old balances **before** any future services will be provided. If a payment plan has been set up and adhered to, future services will be provided. Balances can be resolved with check, cash or credit/debit cards.
2. A total of three statements will be mailed to the patient at the address provided.
3. There will be a $25.00 fee on any returned check. If check is returned payment will be accepted by money order, cash or credit card.
4. All patients will be responsible for co-payments at the time of service. Patients that have deductibles will be responsible for payment of office visit at the time of service. We will gladly submit the claim to your insurance company so that your payment will be reflected in your yearly deductible contribution.
5. Patients who have Medicare only with no secondary insurance provider will be required to pay $20 per visit to avoid billing for the 20% balances. Any credit will be applied to your account for future visits. If you have seen another podiatrist in the last 10 weeks you will be responsible for charges of visit.
6. ALL patients will be required to have a debit or credit card on file. ***Any outstanding balance*** that has not been met and has gone greater than 60 days outstanding will be charged to the credit card on file. We would be responsible for maintaining your private information, just as we do with your health information.
7. It is the patient responsibility to provide up to date billing and contact information at every visit. Once the service has been provided it is the patient (guarantor) responsibility to provide payment.
8. A complementary appointment reminder calling system is a service provided to remind you of your upcoming appointments. The office is not responsible if a call is missed. There will be a $20 missed appointment fee for those that do not call within 24 hours of the scheduled appointment to notify us of cancellation.
9. The office will be happy to set up a payment plan for any outstanding balance. A credit/debit card will be placed on file. An agreed to amount will be deducted from the patient credit/debit card on an agreed to date. A copy of your receipt will be emailed or mailed to the patient. The payment plan will remain in effect until the account has a zero balance. Email address: ___________________________
10. By signing this agreement I am authorizing Southern Delaware Foot & Ankle to charge my credit or debit card for any outstanding balance greater than 60 days outstanding.
11. For outstanding balances >60 days with no payment plan in place or other means put in place to take care of the outstanding balance court filing may commence. I understand I will be held responsible for all court costs associated with filing for judgment or garnishment.
12. We do appreciate all of our patients and their timely settlement of outstanding balances. We will be glad to help anyway possible. Just ask... We humbly thank you for selecting us to care for you.
13. I have read and fully understand the financial policy from Southern DE Foot & Ankle.

Signature of patient: ___________________________ Date: ______________

(If under 18 parent signature or guarantor)