Lyle W Sklar DPM
Diplomat, American Board of Podiatric Surgery

Patient Information

Name: _____ Date of Birth: _____ Age: _____

Address:

_____
Street Apt. # City State Zip

S.S.#: _____-____ -_____ Sex: Male/Female

Phone: Home ( ) _____ Work ( ) _____
Cell ( ) _____

Email: _____ Employer: _____

Emergency Contact:
Name: _____ Relationship: _____

Phone: _____

What is your primary language? _____

Responsible Party (If Not Self):
Name: _____ Date of Birth: _____
Relationship: _____

Address:_____

Phone: _____

How did you hear about our office? _____

I certify that the information given above is true and correct. I understand that it is my responsibility to notify Dr. Lyle Sklar of any changes to the above information.

Patient or Guardian Signature: _____ Date: _____

Foot First Podiatry ASSIGNMENT OF BENEFITS AND FINANCIAL AGREEMENT

My signature at the bottom of this form authorizes payment for services rendered to myself or my dependent to be made directly to Dr. Lyle W Sklar. This authorization is valid until I notify Dr. Sklar in writing that it is revoked.

I understand that I am responsible for giving "Foot First Podiatry" the correct insurance information at the time of service is rendered. Foot First Podiatry agrees to bill your primary insurance carrier. If you have more than one insurance carrier, we will bill your secondary insurance one time as a courtesy. If payment is not received from your secondary within 45 days the balance becomes your responsibility. All insurance information must be provided to our office, at the time of service.

I understand that I am responsible for obtaining the proper referral and may be held responsible for charges not covered by my Insurance due to my failure to obtain the required referral.

I agree to pay for non-covered services under my insurance plan (services for which I have a policy exclusion).

I understand that Foot First Podiatry is not responsible for knowing if the group/physician is a participating provider with my insurance carrier.

We at Foot First Podiatry expect that all accounts should be paid by the receipt of the first two statements. If your account has not been settled either by payment in full or by contacting our billing department to set up a payment plan we will be charging a $10 re-billing fee for each statement sent. Your account will be turned over to collection if you do not fulfill the terms of your financial arrangements.

I understand that there is a fee of $35.00 for all returned checks.

I understand that if I do not call to cancel my appointment within 24 hours there will be a $30.00 fee applied to my account.

I understand that I am responsible for all balances not paid by my insurance carrier, including deductibles, co-pays, and co-insurance and out of network penalties. I further understand that if this balance is turned over to an outside collection agency that I shall be liable for all cost of collection and any attorney fees and/or incurred by this office.

_____

Patient or Patient's Guardian or Legal Representative Signature Date:

_____

Name of Patient or Guardian or Legal Representative Relationship to patient

History & Medical Information

1. Primary Care Physician: _____
Phone: ( ) _____ Date of last visit: _____
2. Height: _____ Weight: _____
3. Explain your foot/ankle problem:
_____
4. When did the pain/discomfort begin?
(Date)_____
Describe pain/discomfort: Burning Numbness Sharp Other: _____
5. What makes pain/discomfort better?
_____
6. What makes pain/discomfort worse?
_____
7. Has condition been treated? YES NO When and How:
_____
8. Past Medical History:

Anemia	Kidney Disease	Other Arthritis	Other: ___
Bleeding Disorders	Heart Disease	Lung Disorders	Prostate Disorders
Cancer	Hepatitis	Nerve Disorders	Rheumatic Fever
HIV/Aids	Neurologic	Stroke	Gout
Diabetes (type I) or (type II)	High Cholesterol	Mitral Valve Prolapse	Thyroid Disorders
Epilepsy	High Blood Pressure	Osteoarthritis	Asthma

9. List all Medications/herbs/vitamins: NONE
_____
_____
What is your current Pharmacy Name? _____ Phone: _____
10. Allergies: NONE

Penicillin	Aspirin	Shellfish
Narcotic Agents/Codeine	Anesthesia	Other: _____
Sulfa Drugs	Radiographic Contrast/Dye	

11. Surgical History:
Have you had Surgery? YES/NO If yes, date & describe: _____
12. Social History: Exercise: Y/N Alcohol use: Y/N Tobacco use: Y/N If yes, how much per day? _____ # of years? _____
Caffeine use: Y/N Drug use: (recreational, IV) Y/N Pregnant: Y/N Nursing: Y/N
13. Occupation/Job: _____
14. Family history: (Indicate F for Father or M for Mother)

Diabetes	Heart Disease	Bleeding Disorders	Mental Illness
High Blood Pressure	Stroke	Kidney Disease	Cancer
Rheumatology	Other Family History: _____		

Foot First Podiatry

1. Constitutional Symptoms:
Fevers Chills Sweats Weight Loss NONE

2. Head, Eyes, Ears, Nose, and Throat:
Do you wear: Contacts Dentures Eyeglasses NONE
Have: Double Vision Difficulty Swallowing Nose Bleeds Cataracts Neck Pain
Sore Throat Ringing in Ears Dizziness NONE

3. Cardiovascular:
Chest Pain/Heart Attack Leg Pain w/Exercise Palpitations NONE
Swelling in Legs/Ankles Heart Murmur
Congestive Heart Failure Cardiovascular Surgery

4. Hematological/Lymphatic (blood) History of:
Bleeding abnormalities Anemia Lump in Groin or Armpit
Swollen Glands Lymphoma NONE

5. Respiratory:
Shortness of Breath Emphysema Asthma Previous Pulmonary Disease
Difficulty Breathing Wheezing Pneumonia NONE
TB Exposure/Treatment Cough Bronchitis

6. Gastrointestinal:
Nausea Vomiting Diarrhea Constipation Stomach Ulcers

7. Endocrine:
Often Thirsty Often Urinating Kidney Disease Pancreatitis
Diabetes Mellitus Prostate Problems Thyroid Disorder NONE

8. Musculoskeletal:
Tendonitis Bursitis Broken Bones Arthralgia
Weakness of Limbs Feeling Weak Joint Pain NONE

9. Nervous System:
Migraines
Ataxia (loss of balance) Seizures Strokes Nervous Disorder
Neuropathy (loss of sensation) Aphasia (loss of speech) Confusion NONE
Speech Difficulties Fainting

10. Integumentary:
Rash Growth on Skin Skin Ulcers Lesions
Change in Skin Color Sensitivity to Sun Keloids Hair Loss
Recurrent Infections Cracking of the Skin Eczema NONE

11. Psychiatric:
Nervousness Tension Depression NONE

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. Patient/Guardian Signature:

_____

Signature Date

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 to) and understand the Notice.

_____

Patient Name (please print) Date

_____

Signature