Family Foot Clinic
A UNITY HEALTHCARE PARTNER

PATIENT'S INFORMATION

Date:_____ DOB:_____Social Security#:_____

Patient Name:_____
Last Name First Name Middle Name

Address:_____
Street City/State Zip Code

E-mail Address:_____

Phone Home:_____ Cell:_____ Work:_____

Marital Status:_____ **Sex** (Circle) M F **Gender Identity** (Circle) M F Both Neither

Race:_____ **Ethnicity** (Circle) Hispanic Not Hispanic

Primary Care Physician:_____

EMPLOYER INFORMATION

(Circle) Full Time Part Time Retired Not Employed Self-Employed Active Military Duty

Employer Name:_____ Employer's Phone:_____

Employer's Address:_____
Street/Mailing City/State Zip Code

EMERGENCY CONTACT & MISCELLANEOUS INFORMATION

Patient Permanent Mailing Address (If applicable for college students)

_____
Street City/State Zip Code

Emergency Contact Name:_____

Emergency Contact Phone:_____ Relationship:_____

REFERRAL INFORMATION

How were you referred to us (Circle) Physician Emergency Room/Urgent Care Employer Family Member/Friend

Website TV Newspaper Radio Other _____

If physician or medical facility referral, please list name:_____

INSURANCE INFORMATION

Primary Insurance Co. :_____

Subscriber's Name:_____ DOB:_____Subscriber's SS#:_____

Subscriber's Address:_____
Street City/State Zip Code

Subscriber's Relationship to the Patient:_____

Subscriber's Employer:_____

Secondary Insurance Co.:_____

Subscriber's Name:_____ DOB:_____Subscriber's SS#:_____

Subscriber's Address:_____
Street City/State Zip Code

Subscriber's Relationship to the Patient:_____

Subscriber's Employer:_____

Third Insurance Co. :_____

Subscriber's Name:_____ DOB:_____Subscriber's SS#:_____

Subscriber's Address:_____
Street City/State Zip Code

Subscriber's Relationship to the Patient:_____

Subscriber's Employer:_____

PARENT INFORMATION
(if minor child)

Father's Name:_____
Last Name First Name Middle Name

Father's Home Address:_____
Street City/State Zip Code

Father's Phone: Home:_____ Cell:_____ Work:_____

Father's Employer:_____SS#:_____

Father's Employer Address:_____
Street City/State Zip Code

Mother's Name:_____
Last Name First Name Middle Name

Mother's Home Address:_____
Street City/State Zip Code

Mother's Phone: Home:_____ Cell:_____ Work:_____

Mother's Employer:_____SS#:_____

Mother's Employer Address:_____
Street City/State Zip Code

Family Foot Clinic
A UNITY HEALTHCARE PARTNER

Nicholas P. Costidakis, D.P.M.
975 Mezzanine Drive, Suite B
Lafayette, IN 47905
PH: 765.447.4776
FX: 765.447.4809

Medical History

Patient Name: _____ Date: _____

Height : _____ Weight : _____ Blood Pressure:_____ Do you have Diabetes? □ Y □ N

Occupation:_____

What type of foot/ankle problem are you having? _____

_____

Do you smoke? □ Y □ N □ Current Smoker □ Former Smoker □ Never

Do you exercise and/or play sports? (please list): _____

_____

Have you seen a podiatrist before? □ Y □ N Who:_____Last Visit:_____

Medications: □ None

Drug Name	Dose	Times Per Day	Drug Name	Dose	Times Per Day
Aspirin / Blood Thinners?					

Allergies: □ None

Drug or Medication Name	Reaction or Side Effect
Adhesives / Tapes / Latex?	
Seafood?	

Patient Name: _____ Date: _____

Surgical History: □ None

Operation	Year	Operation	Year

Personal/Family Medical History: □ None
(please mark with an (√) a history of the following with either **yourself** or **other family (mother, father, brother or sister)** member)

Medical Condition	Self	Other	Medical Condition	Self	Other
Anemia			High Cholesterol		
Arthritis			HIV/AIDS		
Bleeding Disorders			Injury/Fracture		
Cancer (Skin)			Kidney Disease		
Cancer (Other) List:_____			Liver Disease		
Chronic Chest Pain			Low Back Pain/Trauma		
Circulatory Problems			Muscle Joint Pain		
COPD			Nervous System Problems		
Diabetes, Type I			Neuropathy		
Diabetes, Type 2			Osteoarthritis		
Eye Problems			Osteoporosis		
Fibromyalgia			Rheumatoid Arthritis		
Gout			Stroke		
Heart Attacks			Swelling Legs or Feet		
Heart Disease			Tired Feet		
Heart Murmurs			Total Joint Replacement		
Hepatitis			Ulcers (feet)		
High Blood Pressure			Varicose Veins		

UNITY HEALTHCARE, LLC
DISCLOSURE AND RELEASE AUTHORIZATION FORM

CONSENT TO TREAT: I request and give consent to my physician to provide and perform such medical/surgical care, tests, procedures, drugs and other services and supplies as my physician, in his/her professional judgment, deems necessary or beneficial. I acknowledge that no representations, warranties or guarantees as to the results or cures have been made to me or relied upon by me.

_____
Intl

RELEASE OF MEDICAL INFO AND AUTHORIZATION TO PAY INSURANCE BENEFITS: I authorize Unity and my physician to release information from my medical records to my insurance carrier(s), governmental agency, or my employer in the case of work-related injuries, for the purpose of processing claims for medical/workers compensation benefits and state on such claims that my signature is on file. I request that my insurance company(s) honor my assignment of insurance benefits applicable to the services and pay all assigned insurance benefits directly to my physician, on my behalf.

_____
Intl

FINANCIAL AGREEMENT: I understand all accounts are the full responsibility of the patient and/or the patient's responsible party guarantor. My physician will assist patients in obtaining insurance benefits when those benefits are assigned to my physician. It is the patient's responsibility to make sure insurance payments are processed and paid promptly to my physician. In the case of default payment, I promise to pay any legal interest on the balance due, together with any collection costs and reasonable attorney fees incurred to effect collection of this account of future outstanding accounts. I agree that reasonable attorney fees shall be interpreted as 40% of any balance due at the time the account is sent to an attorney or collection agency for collection, or $300.00, whichever is greater.

_____
Intl

MEDICARE CERTIFICATION: I certify that the information given by me, or by Unity on my behalf, in applying for payment under Title XVIII of the Social Security Act is correct. I authorize my treating physician to release information from my medical record to the Social Security Administration and/or Medicare program or its intermediaries or carriers, or the Professional Standards Review Organizations for the purpose of processing of claims for medical benefits and state on such claims that my signature is on file. I request that payment of such authorized benefits be made directly to my treating physician on my behalf.

_____
Intl

TELEPHONE CONTACTS: I authorize Unity Healthcare, LLC and its affiliates and agents to contact me at the phone numbers I have provided (whether such is a cell phone or a land line), including providing me with automated appointment reminders and other automated calls related to the services provided to me. If a machine or voice mail is reached I understand a message may be left for me. (If you are receiving treatment from multiple Unity Healthcare providers, it may result in multiple calls.)

_____
Intl

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES: I have received the Practice's Notice of Privacy Practices and understand that my protected health information maybe used by the Practice as described in the notice.

_____
Intl

INDIANA LAW AND JURISDICTION: I understand that I am being provided treatment in the State of Indiana and I agree that if I should have any claim with regard to my care or treatment, such will be decided in accordance with Indiana law and such action will be brought and decided in a Court in the State of Indiana.

_____
Intl

NOTICE OF NONDISCRIMINATION: Unity Healthcare, LLC complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, sex or gender identity.

_____
Intl

OTHER PROVIDERS: I understand in addition to the attending physician, other physicians, such as radiologists and pathologists, and other providers such as laboratories and other medical professionals, may be involved in my care, and may separately bill me for their services.

_____
Intl

Patient Name/Signature: _____ Date:_____
Parent/Guardian Signature: _____ Date:_____

UNITY HEALTHCARE, LLC
HIPAA RELEASE OF INFORMATION

Name: _____ DOB___/___/_____

Due to HIPAA rules and regulations, we are not permitted to discuss your medical information with anyone, including your family, without your consent or unless an exception to the rule applies (e.g. provider-to-provider discussions related to your treatment or to collect payment).

Please list individuals (other than providers) we may speak with regarding your care:

Name:	Relationship:	Phone:
1._____	_____	_____
2._____	_____	_____
3._____	_____	_____

A photocopy of this authorization shall be considered as valid as the original. **This Release of Information will remain in effect until terminated by the patient in writing.**

Patient Signature:_____ **Date___/___/_____**