GIEVERS-ZUNIGA FOOT & ANKLE CENTER
18111 PRINCE PHILIP DR #328
OLNEY, MD 20832
P-(301)570-3668
F-(301)570-4770
WWW.GIEVERSZUNIGAFOOT.COM

Patient Demographics

Last Name	First name	M.I	D.O.B	Age	Gender(circle) M- F	SSN

Home Address:	Apt/Lot	City	State	Zip code

Occupation: (circle) Student - Full Time - Part Time - Retired - Unemployed

Marital Status (circle)	Mother's Name if patient is a minor:	Father's Name if patient is a minor:
☐Single ☐ Married ☐Widowed ☐Separated ☐Divorced		

Home #	Work #	Cell phone #	Email Address:
( ) -	( ) -	( ) -	

Emergency Contact Name:	Address:	Phone Number:
Primary Care Doctor:	**Address:**	**Phone Number:**

Insurance Information

Name of Primary Insurance:	Name Of Secondary Ins:	Name of Tertiary Ins:
Name of Policy holder if different then Patient:	**Name of Policy holder if different then Patient:**	**Name of Policy holder if different then Patient:**
D.O.B of Policy Holder:	**D.O.B of Policy Holder:**	**D.O.B of Policy Holder:**

policy #	group #	(policy #)	(group #)	(policy #)	(group#)

Pharmacy information

Name:	Address:
Phone Number:	

Consent to Speak or Leave Message

You have the right to request restrictions on certain uses and disclosures of protected health information including those related to disclosures to family members, other relatives, close personal friends, and any other person identified by you.

With whom may we share your medical information?_____

May we leave medical information on your answering machine? Circle one: YES (please circle one) Home / Cell / or Email address NO

Authorization to Release Information

I authorize Gievers-Zuniga Foot & Ankle Center to bill my insurance on my behalf for services rendered and further authorize payment of any to which I am entitled to Dr. Donna Gievers-Zuniga. I understand that I am financially responsible for any amount not covered by the contract. I authorize her to release to my insurance carrier any information concerning my health care, advice, treatment or supplies provided which may be necessary to secure payment of these claims.

_____ _____

Signature of Patient/Responsible Person Date

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PLEASE SPECIFY THE REASON WHY YOU ARE HERE TODAY?(up to 2 problems per visit)

1. _____
2. _____

PAIN ASSESTMENT

Indicate your level of pain on a scale of 1-10.

(10=worst pain imaginable)1 2 3 4 5 6 7 8 9 10

Check the symptoms that best describe your problem:

☐ Stiffness ☐ Pain ☐ Swelling ☐ Instability ☐Numbness ☐ other: _____

PODIATRY

Do you have any of the following?

☐Ankle Pain ☐Arch Pain ☐Athlete's Foot ☐ Broken Ankle ☐Broken Foot bones ☐Bunions
☐Burning in Feet ☐Corns/Calluses ☐Cramps in Feet ☐Cramps in Legs ☐Enlarge Veins ☐Flat Feet
☐Foot Numbness ☐Foot Ulcers ☐Fungal Nails ☐High Arch Feet ☐Heel Pain ☐Hammer Toes
☐Ingrown Nails ☐In-toeing ☐Knee Pain ☐Leg Ulcers ☐Loss of Sensation in feet
☐Lower Back Pain ☐Rash in Feet ☐Swelling in Ankles ☐Swelling in Legs ☐ Tingling in Feet

_____

Do you currently or have ever worn orthotics? ☐ Yes ☐ No Does your foot pain limit your desired activity? ☐ Yes ☐ No
Are your first steps out of bed in the morning painful? ☐ Yes ☐No

Have you ever had any other foot pain? ☐Yes ☐No If yes, please describe: _____

LIFE STYLE FACTORS

*Do you smoke ? ☐Yes: How many per day? _____ _____ ☐NO

∗What type of shoes do you wear? ☐ Flats ☐ Heels ☐Boots ☐ Loafers ☐Oxfords ☐ Sneakers ☐Other: _____

∗SHOE SIZE: _____N_M_W_XW ***Height: _____** ***Weight:_____**

Hospitalizations & Surgeries

Current Medications

What medications are you taking?			

Are you taking any Blood Thinners? ☐ Yes :_____ ☐ No

PATIENT NAME:

Allergies

Are you allergic to any of the following?

☐ Adhesive Tape ☐ Latex ☐Aspirin ☐Sulfa ☐Codeine ☐iodine ☐Local Anesthetics

☐ Antibiotics:_____ Do you have any other allergies?_____

Patient past Medical History/Current

Have you ever had any of the following?

☐ Alcoholism ☐ Allergies
☐ Anemia ☐ Anxiety Disorder
☐Arthritis ☐ Asthma
☐ AIDS/HIV ☐ Back Problems
☐ Bleeding Disorder ☐ Cancer
☐Diabetes ☐Depression

☐ Ear Problems
☐Eating Disorder
☐Epilepsy ☐Glaucoma
☐Gout ☐ Heart Disease
☐Hepatitis A, B or C
☐ High Blood Pressure

☐High Cholesterol
☐Joint Disorder
☐Kidney Disorder
☐Liver Disorder
☐Lung Disorder ☐Measles
☐Migraines ☐Osteoporosis

☐Pneumonia ☐Polio ☐Rheumatic Fever ☐Stroke ☐Skin Disorder
☐Stomach Ulcer ☐Substance Abuse ☐Thyroid Disorder ☐Tuberculosis ☐Venereal Disease

Women Only

Are You Pregnant? ☐ Yes ☐No Are you Breastfeeding? ☐ Yes ☐No

Family Medical History-(CHECK THE ONE THAT APPLIES!!!!!)

	DIABETES	HEART PROBLEMS	HIGH CHOLESTEROL	HIGH BLOOD PRESSURE	CANCER	OTHER	OTHER
MOTHER							
FATHER							
SISTER							
BROTHER							
GRANDMOTHER							
GRANDFATHER							

PATIENT NAME:

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Payment Policy

We are committed to providing you with the best possible care. If you have medical insurance, we are eager to help receive your maximum allowable benefit. We do, however, need your assistance and understanding of our payment policy.

- If you don't have insurance we require full payment at the time of visit.
- Copayment is required at the time of service. We accept cash, checks, Visa and MasterCard.
- In the event that the courtesy of filling your insurance claim is extended to you, you must realize that all charges are your personal responsibility from the date of services is rendered.
- Due to ever-changing health insurance laws and regulation, we cannot guarantee that all services will be covered by your insurance policy.
- In the event that your insurance does not cover your services, you will be held responsible for payment.

Failure to pay bills will result in your account being referred to a collection agency and/or attorney. All collection and attorney fees, expenses and court costs will be the responsibility of the patient or the person responsible for the account.

- **A fee of $30.00 will be charged for any returned checks.**
- **A fee of $50.00 will be charged for any appointments that are missed or cancelled without 24 hours' notice.**

If you have any questions concerning these policies or any uncertainty regarding insurance coverage, please do not hesitate to ask us.

Please sign and print name below to indicate that you have read and understand this payment policy.

_____ _____

Signature of patient/responsible person Date

_____

Print name of patient/responsible person

Law Requires Us to:

1. Keep your medical information private.
2. Give you this notice describing our legal duties, privacy practices, and your rights regarding your medical information.
3. Follow the terms of the current notice.

We have the Right to:

1. Change our privacy practices and the terms of this notice at any time, provided that the changes are permitted by law.
2. Make the changes in our privacy practices and the new terms of our notice effective for all medical information that we keep, including information previously created or received before the changes.

USE AND DISCLOSURE OF YOUR MEDICAL INFORMATION

The following section describes ways that we use and disclose medical information. Not every use or disclosure will be listed. However, we have listed the different ways we are permitted to use and disclose medical information. We will not use or disclose your medical information for any purpose not listed below, without your specific written authorization. Any specific written authorization you provide may be revoked at any time by writing to us at the address provided on the top of this notice.

FOR TREATMENT: We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, medical students, health care providers to assist them in treating you.

FOR PAYMENT: We may use and disclose you medical information for payment purposes. A bill may be sent to you or a third-party payer. The information on or accompanying the bill may include your medical information.

FOR HEALTH CARE OPERATIONS: We may use and disclose your medical information for our health care operations. This might include measuring and improving quality. Evaluating the performance of employees, conducting training programs, and getting the accreditation, certificates, licenses and credentials we need to serve you.

ADDITIONAL USES AND DISCLOUSES: In addition to using and disclosing your medical information for treatment, payment, and health care operations, we may use a disclose medical information for the following purposes

- Court orders and Judicial and Administrated Proceedings
- Public Health Activities-Required by law
- Victims of abuse, neglect, or Domestic Violence
- Workers Compensation
- Health Oversight Activities
- Law Enforcement
- Alternative and Additional Medical Services.

YOUR INDIVIDUAL RIGHTS

You have the Right to:

To have access to and/or a copy of your health information;
- To receive an accounting of certain disclosures we have made of your health information;
- To request restrictions as to how your health information is used or disclosed;
- To request that we communicate with you in confidence;
- To request that we amend your health information:
- To receive notice of our privacy practices.

I _____Acknowledge that I was Provided upon my request a copy and/or had the chance to read and understood the notice.

_____ _____

Signature Of patient or Legal representative

_____ _____

Patient's name if Under Age Today's Date

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