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NEW PATIENT HISTORY INTAKE

Today's Date _____

To our new patients: *Welcome* to East End Foot & Ankle. To help us establish you with our practice, please provide us with your complete health history. To our established patients: Thank you for returning and welcome back.

Patient Information

Full Name: _____ Date of Birth: _____ Age: _____

Preferred Name (If Different Than Legal Name): _____ Race/ Ethnicity: _____

Social Security Number: _____ Preferred Language: _____ Marital Status: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

E-mail: _____

Employer Name and Occupation: _____

Primary Care Physician: _____ Date of Last Visit: _____

Were you referred by someone? _____ If yes, Who?: _____

How did you hear about our office? _____

Pharmacy Name, Phone Number, and Location _____

Responsible Party- Financial Name, Date of Birth, Address, Social Security Number, and Relationship to Patient:

Describe your foot and/or ankle problems, including right or left.

Duration: _____ Injury related? If yes, when?: _____

What treatment(s) have you received before your visit today? _____

Past Medical History and Family History Check all that apply:

	Yourself	Mother	Father		Yourself	Mother	Father
AIDS/HIV				High Blood Pressure			
Alcoholism				High Cholesterol			
Anemia				Kidney Disease			
Arthritis				Liver Disease			
Asthma/COPD				Sickle Cell Anemia			
Cancer				Acid Reflux/Ulcers			
Circulation Problems				Stroke			
Diabetes				Depression/ Anxiety			
Heart Disease/Attack				Gout			
Heart Trouble				Fibromyalgia			
Hepatitis				Other not listed:			

Height _____ Weight _____ Shoe Size _____

Medications: (Or indicate that list is attached)

Allergies. Please circle and indicate type of reaction. Include any not listed.

	Reaction		Reaction
Codeine/Hydrocodone		Sulfa Drugs	
Shellfish		Latex	
Adhesive Tape		Antihistamines	
Penicillin		Other:	

Surgical History and Hospitalizations. Include the date.

Social History.

Do you (did you)smoke cigarettes? _____ Packs per day? _____ How long? _____

Do you drink alcohol? _____ Type: _____ Drinks per week: _____

Do you use recreational drugs? _____ Type: _____

Any type of exercise? Describe. _____

Review of Systems. Check any that *currently* apply to you.

Constitutional:

- poor appetite
- fever
- chills
- weight loss/gain
- fatigue
- depression

Cardiovascular:

- chest pain
- palpitations
- ankle swelling
- varicose veins
- calf cramps

Musculoskeletal:

- neck/back pain
- hip/knee pain
- muscle weakness

GU:

- painful/frequent urination
- kidney stones

HEENT:

- headaches
- wear glasses/contacts
- ringing in ears
- dizziness
- sore throat
- sinus problems
- seasonal allergies

Respiratory:

- shortness of breath
- difficulty breathing
- cough

GI:

- nausea/vomiting/diarrhea
- heartburn
- abdominal pain

Skin:

- rash
- eczema
- itching

Neurological:

- loss of coordination
- seizures
- numbness in limbs
- tingling/burning in limbs

Please check here if all of the above symptoms are negative.

I confirm that the above information is true and complete.

Sign: _____ Today's Date: _____



Financial Policy and Privacy Practices

Thank you for choosing Dr. Adam Didyk and Dr. Angela Binns Didyk as your podiatrists. Please be advised our office has a few policies that you need to be aware of. **Please read and initial each item.**

- __1. If your insurance company requires a referral we require 7-10 days notice of your scheduled appointment. Emergency situations will be taken into consideration. The referrals can be faxed to us at (502) 426-4420. You will be responsible for making sure that the referral is received.
- __2. All co-payments will be collected prior to service being rendered. All co-insurance and deductibles are payable after services are rendered. We accept most major credit cards, cash, and personal checks.
- __3. Please bring in a list of your medications every time your medications have changed. We need to continuously update your chart. **You are responsible for informing our office of all insurance, address, employer and telephone number changes.**
- __4. You will possibly be charged for a missed appointment. Please call **24 hours in advance** if you cannot keep the appointment.

I, the undersigned, hereby consent to any X-rays, diagnostic tests and treatment procedures considered advisable in the judgment of the physician on duty. I further consent to the release of information regarding my condition and treatment to my attorney and/or involved insurance companies. I authorize any insurance company and/or my attorney to disclose the status of my claim and/or the settlement agreement to East End Foot & Ankle (EEFA).

This medical history record has been designed to facilitate our patient's continuity of care at EEFA. This is a confidential record and will be kept in this facility. Information contained here will not be released to anyone without your documented authorization to do so. I understand I may be charged a reasonable cost-based fee should I need copies of certain medical records, such as X-rays. 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 chose) and understood the Notice.

I, hereby, irrevocably assign, and transfer any and all medical benefits payable to me and further direct any insurance company from which I am entitled benefits to pay such medical benefits directly to EEFA. The undersigned agrees to be liable for any and all charges by EEFA including, but not limited to, any deductibles, copayments, and percentages as directed by my insurance company, or fees not paid by my insurance company. This Assignment does not release patient's obligation to such charges. EEFA will immediately file any insurance for which you are entitled benefits.

Any balance on my account not paid by my insurance carrier within 60 days will become my responsibility and understand I will be responsible for these payments. I understand that EEFA is unable to act as an intermediary between myself and my insurance carrier. I understand that I am responsible for contacting a customer service representative should I feel dissatisfied with my claim denial and feel my service should be covered. If, in error, my insurance company sends a check directly to me for payment of services received at this clinic, I agree to bring the misdirected check to this clinic within 48 hours.

I have read the above and agree to the terms.

Date Patient/or Guardian signature / Date EEFA Representative Signature