Southern Maine
Foot & Ankle, PA
Medicine and Surgery of the Foot and Ankle

Peter T. Ocampo D.P.M.

NEW PATIENT

PLEASE FILL OUT THE ATTACHED FORMS AND SIGN ON THE X'S BEFORE COMING TO YOUR APPOINTMENT. DO NOT MAIL BACK.

IF YOU HAVE XRAYS OF YOUR FOOT OR ANKLE PLEASE BRING ALONG WITH YOU TO YOUR APPOINTMENT.

1. **THE ATTACHED FORMS MUST BE DATED FOR THE DAY OF YOUR APPOINTMENT. PLEASE BRING YOUR INSURANCE CARD(S) WITH YOU. IF AN HMO POLICY BE SURE TO CALL YOUR PRIMARY PHYSICIAN BEFORE THE DAY OF YOUR APPOINTMENT**
2. **PLEASE BRING A PHOTO ID (DUE TO IDENTITY THEFT)**
3. **YOUR CO-PAY WILL BE DUE AT THE TIME OF THE VISIT**

IF YOU HAVE ANY QUESTIONS PLEASE DO NOT HESTITATE TO CALL THE OFFICE

Scarborough ŏ 25 Plaza Dr. Suite 9 ŏ Phone (207) 883-0865 ŏ Fax (207) 883-0913
Windham ŏ 584 Roosevelt Trail (Route 302) ŏ Phone (207) 892-5072

WWW.SMFOOTANDANKLE.COM

SOUTHERN MAINE FOOT AND ANKLE, PA

SCARBOROUGH 883-0865 **WINDHAM 892-5072**
25 Plaza Dr. Suite 9 **584 ROOSEVELT TRAIL (RTE 302)**

Patient Name:_____ Todays Date:_____
Address:_____ Occupation:_____
City:_____ State:_____ Zip: _____
Date of Birth :___ / ___ / _____ Age:_____ Male:____ Female:_____
SS: _____-_____-_____ Home Phone #: ( )_____ Work #: ( )_____
Employer:_____ Address:_____

Emergency Contact: Spouse/Parent: _____
Address:_____ State: _____ Zip: _____ Phone #: _____

If Patient is a Child:
Mother's Name: _____ DOB: ___ / ___ / _____ SS: ____ - ____ - ____
Address: _____ State: ____ Zip: _____ Phone #: ( ) _____
Employer: _____ Work #: ( ) _____

Father's Name: _____ DOB: ___ / ___ / _____ SS: ____ - ____ - ____
Address: _____ State: _____ Zip: _____ Phone #: ( ) _____
Employer: _____ Work #: ( ) _____

All Patients:
How Did you find our practice? Yellow Pages (Verizon or Talking Phone Book); Internet
Friend/Family Member Insurance Doctor Referral (Who): _____
Other: _____

What bothers you? FOOT ANKLE RIGHT LEFT BOTH

Date of Injury/How long bothering? _____
Describe how it feels: _____
Any Treatment: _____ By Whom? _____
Any tests already taken: ___ X-ray ___ CT ___ MRI ___Ultrasound

Family Doctor: _____ Date of Last Visit: ___ / ___ / _____

ACKNOWLEDGEMENT: I have reviewed the above information and verify that it is correct. I understand all charges are due and payable in full at the time of service and will abide by this policy. I authorize any and all insurance companies to pay benefits to the doctor. I authorize the release of medical information necessary in handling my claims.

SIGNATURE: _____ Date: _____

Review of Systems

Please put a **check ()** next to all of the symptoms below which you have experienced. If you do not know the answer or do not understand the question, **insert a question mark(?)**

GENERAL:
___ Recent weight gain
___ Recent weight loss
___ Fatigue currently
___ Recent Fever
___ Recent Change in appetite
___ Recent Change in sleep pattern
___ None of the Above Apply

RESPIRATORY:
___ Pneumonia
___ Tuberculosis
___ Asthma
___ Chronic Bronchitis
___ Emphysema
___ Cough up Blood
___ Wheezing
___ Night Sweats
___ None of the Above Apply
When was your last chest X-ray?_____
Have you ever had an abnormal Chest x-ray? YES NO

CIRCULATORY/CARDIAC:
___ Heart Murmur
___ Heart Attack
___ Chest Pain
___ High Blood Pressure
___ Mitral Valve Prolapse
___ EKG Date:_____
___ Cramping with Activity
___ None of the Above Apply

DIGESTIVE:
___ Ulcer
___ Hernia
___ Vomit Blood
___ Bloody Stool
___ Hepatitis
___ Liver problem
___ Diverticulitis
___ Chronic Diarrhea/Colitis
___ None of the Above Apply

ENDOCRINOLOGY:
___ Glandular/Hormone Problem
___ Thyroid Disease
___ Diabetes
___ None of the Above Apply

SKIN:
___ Any recent rashes or lumps
___ Any current Skin Infections
___ None of the Above Apply

ANESTHESIA:
___ Problem with Anesthesia
___ Family History of Problems with anesthesia
___ Malignant Hypothermia
___ None of the Above Apply

HEMATOLOGY:
___ Anemia
___ Bleeding or bruising Tendency
___ Cancer
___ X-ray Therapy
___ Phlebitis
___ Blood Clots - DVT
___ Frequent Bloody Nose
___ Bleeding Gums
___ HIV
___ None of the Above Apply

URINARY:
___ Bladder Infection
___ Kidney Disease
___ Blood in Urine
___ Kidney Stones
___ Prostate Problems
___ None of the Above Apply

NEUROLOGICAL:
___ Loss of Consciousness
___ Convulsions/Seizures
___ Head Injury
___ Stroke / CVA
___ Paralysis
___ Nervous Breakdown
___ Depression/Nervousness
___ Psychiatric Problem
___ Other: _____
___ None of the Above Apply

DENTAL:
___ Chronic Infections
Date of Last Dental Appointment: _____

EYES:
___ Glasses
___ Glaucoma
___ Macular Degeneration
___ Other: _____
___ None of the Above Apply

Are you Currently Pregnant? YES NO

Name: _____

Date: _____

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584 ROOSEVELT TRAIL (RTE 302)

Please complete this form to the best of your ability. Please answer all questions. If you don't know the answer or don't understand the question, mark in the space. **Please do NOT leave blank spaces!**

Surgical History

Please List ALL prior hospital admissions and operation along with the date.

_____
_____
_____
_____
_____

MEDICAL CONDITIONS

___ High Blood Pressure
___ Gout
___ High Cholesterol
___ Hypothyroidism
___ Diabetes
___ Depression/Anxiety
___ Fibromyalgia
___ Asthma
___ DVT / Blood Clots
___ OTHER: _____
___ None of the above apply
___ HIV
___ Hepatitis

MEDICATIONS

Dose and Frequency

_____
_____
_____
_____
_____
_____
_____
_____
_____

ALLERGIES TO MEDICATIONS

___ NONE ___ Latex ___ Sulfa Drugs
___ Penicillin ___ Codeine
Other: _____

PATIENT NAME: _____

Date of Birth: _____

Height: _____ Weight: _____

Primary Care Doctor: _____

SOCIAL HISTORY

TOBACCO: ___ pack/day ___ years ___ NONE
___ Quit When? _____

ALCOHOL: _____ ___ NONE

LIVING SITUATION: ___ Single ___ Married
___ Widowed ___ Other: _____

Number of Children: ____

Occupation: _____

Activity/Hobbies:

_____
_____
_____
_____
_____
_____

Family History

___ Diabetes
___ Cancer
___ Heart Disease
___ High Blood Pressure
___ Blood Clots
___ Liver Disease
___ Psychiatric Disease
___ Anesthesia Problems
___ Other: _____
___ None of the above apply

Signature: _____

Date: _____

Southern Maine Foot and Ankle, PA

Payment Insurance Coverage and Information Release

Confidential

1. Medical billing and payment procedures are often complex and difficult to understand for patients and their families. Most patients are covered by some form of group health insurance that will pay a large percentage of the cost of care. When you provide us with current and accurate insurance information, we can successfully file most claims on your behalf.

2. In addition to any private insurance carrier information, patients covered under Workers Compensation insurance should present all information and records associated with a work-related injury and claim, including policy number, and date of work - related injury.

3. Some of the costs of your care such as **"Co-Payments"** and Deductibles, may not be covered by your group insurance plan. Payment of any co-payment will be due at the time of your appointment. If not able to pay at the time of service a **$2.00 service fee** will be assessed. Policy deductibles will immediately become the responsibility of the patient, once we are so notified by your insurance carrier.

4. **Self Pay** - No insurance coverage patients:
These patients will be expected to remit up to **$250.00 of your initial visit costs at the time of the first visit.** It is the policy of this office for full payment within twelve months from initial visit with a minimum monthly payment of $100.00.

5. Collection Service - In the event a collection service must be used, you will be liable for all fees, in addition to the outstanding debt.

6. No Show / Cancellation Fee: (24 hour notice required) $20.00

7. NSF / Returned Check Fee: $20.00

Signature below serves to acknowledge your understanding of payment policies and your responsibility.

Signature:
Print Name: _____ Date:_____

Southern Maine Foot & Ankle, PA

I, _____, authorize Southern Maine Foot & Ankle, P.A., and it's employees and agents (collectively referred to as "SMFA") to disclose my health care information to health care practitioners and health care facilities who are involved in providing my health care and with my family or close friends who are providing me with emotional support as I receive health care services. I also authorize SMFA to disclose my health care information to my health insurance carrier, utilization review organization, or benefit manager to support payment for my health care.

I understand that SMFA will disclose only the minimal amount of my health care information that is necessary, in the judgment of SMFA, for the legitimate needs of the recipient or for my general well being.

My health care information that is the subject of this authorization to disclose includes information written or not, about the preventative, diagnostic, or treatment services provided to me and that may be used to identify me. Depending upon the services I request from SMFA, this information may include information about treatment for HIV/AIDS, sexually transmitted diseases, mental health or psychiatric conditions or substance abuse.

I understand that I may refuse to disclose all or some health care information and that I may revoke this authorization at any time by providing SMFA with a written, signed, and dated request. However, I understand that my refusal to disclose all or some health care information or to provide this authorization at this time may result in improper diagnosis or treatment, denial of coverage of a claim for health benefits or other insurance, or other adverse consequences.

Southern Maine Foot & Ankle P.A., employees and agents regards the safeguarding of your confidential health care information as an important duty. The elements of this authorization to disclose are required by state law for your protection and to ensure your informed consent to the disclosure for health care information necessary to support your relationship with SMFA.

Should you wish to have a copy of this authorization or should you have any questions about it or about SMFA policies for safeguarding your health care information, please ask the office staff or your physician.

_____ _____

Signature of Patient or Parent or Legal Guardian Date

Southern Maine Foot & Ankle

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 chose) and understood the Notice.

_____ _____

Patient Name (please print) Date

_____

Parent or Authorized Representative

_____

Signature

Name:_____ ***DOB***:_____

Today's Date: _____

Foot and/or Ankle Issues:

Describe your foot/ankle problem: _____

_____

How long have you had this problem? _____

Have you had any treatments for this problem? If so, describe. _____

_____

Is there anything else you'd like us to know related to your visit today? _____

_____

Is there anything special you'd like to discuss with the doctor today? _____

_____

_____

All health care offices have been mandated to collect the following information under the American Recovery and Reinvestment Act of 2009 and subsequently the Meaningful Use regulations imposed by The Centers for Medicare & Medicaid Services. The information collected is de-identified and reported to The Centers for Medicare & Medicaid Services.

1. What is your primary language? ❒ English ❒ Spanish ❒ French

   ❒ Other:_____

2. Please select your race:
   - ❒ American Indian or Alaskan Native
   - ❒ Asian
   - ❒ Black or African American
   - ❒ White
   - ❒ Native Hawaiian or other Pacific Islander

3. Please select your ethnicity:
   - ❒ Hispanic or Latino
   - ❒ Not Hispanic or Latino

For Office Use Only:

Height:_____ Weight:_____ B/P:_____