



McKinney Podiatric Associates, P.A.

Scott W. McKinney, DPM
Jorge Cuza, DPM
Angela Dagley, DPM
Mark Moss, DPM
Francisco Cuza, DPM

HELLO! WELCOME TO OUR OFFICE!

Please print the following information.

Date This information is important for our records and your health.

Patient Name: Birthdate: Age

Address:

City State Zip

Home phone Email

Work phone Employed by

Work address City

State Zip Sex: M F Marital Status: S M D W

Social Security No Family Physician

Referred to our office by

Contact in case of emergency Phone No

Insured's Name Relationship

Insured's Employer Insured's work #

Insured's SS # Insured's Birthdate

Primary Insurance Address

Group #

Secondary Insurance Address

Group #

PATIENT OR AUTHORIZED PERSON'S SIGNATURE

I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment.

Signature

Nature of foot problem

My foot problems involve my Left foot right foot both feet

It has troubled me for weeks months years

Have you had previous care by a Podiatrist? Yes How recently? No

Shoe Size Weight Height

Please continue to the next page

Please circle "yes" or "no" to the following questions:

- |  |     |    |
|--|-----|----|
| Are you now or have you been under a doctor's care during the past two years                                       | Yes | No |
| Are you subject to prolonged bleeding  | Yes | No |
| Have you had a recent weight gain or loss  | Yes | No |
| Do you ever experience numbness or tingling in your feet or legs   | Yes | No |
| Have members of your immediate family (parents, grandparents, or Children) ever had foot problems similar to yours | Yes | No |
| Do your ankles turn, roll in, or sprain easily   | Yes | No |
| Do you ever have stiffness in your foot joints in the morning or evenings  | Yes | No |
| Do you ever get pains, cramps, tightening of the muscles in your feet/legs   | Yes | No |

Does your job require \_\_\_\_\_ walking \_\_\_\_\_ standing \_\_\_\_\_ both

Number of hours averaged on your feet each day \_\_\_\_\_

How is your general health \_\_\_\_\_ good \_\_\_\_\_ fair \_\_\_\_\_ poor

Have you ever been treated for any of the following?

- |                           |                             |                                |
|---------------------------|-----------------------------|--------------------------------|
| _____ Diabetes            | _____ Tumors or Growths     | _____ Liver Problems           |
| _____ Stomach Ulcer       | _____ Difficulty in Hearing | _____ Anemia                   |
| _____ Rheumatic Fever     | _____ Epilepsy              | _____ Stroke                   |
| _____ Shortness of Breath | _____ Tuberculosis          | _____ Varicose Veins           |
| _____ High Blood Pressure | _____ Kidney Problems       | _____ Blood Clots or Phlebitis |
| _____ Gout                | _____ Heart Trouble         |                                |

Are you taking any medicine at the present time? \_\_\_\_\_ Yes \_\_\_\_\_ No

If yes, please list: \_\_\_\_\_

Have you ever experienced any adverse effects from any of the following?

- |                   |                      |                           |
|-------------------|----------------------|---------------------------|
| _____ Penicillin  | _____ Aspirin        | _____ Cortisone           |
| _____ Novocain    | _____ Tape           | _____ Codeine             |
| _____ Sulfa Drugs | _____ Any Antibiotic | _____ Other (please list) |

List any serious illnesses: \_\_\_\_\_

List all operations \_\_\_\_\_

I HEREBY GIVE MY PERMISSION TO THIS OFFICE TO EXAMINE AND TREAT MY FEET AS INDICATED

Date \_\_\_\_\_

Signature \_\_\_\_\_

**MCKINNEY PODIATRIC ASSOCIATES, P.A.**

**Scott W. McKinney, DPM  
Jorge Cuza, DPM  
Angela Dagley, DPM  
Mark Moss, DPM  
Francisco Cuza, DPM**

**POLICY FOR INSURANCE PPO'S AND HMO'S**

If you are covered under an HMO or PPO insurance with your company, it is YOUR RESPONSIBILITY to notify the receptionist that you are on a certain plan and give your card and/or referral BEFORE SERVICES ARE RENDERED. Should you NOT have your insurance card and/or referral with you at the time of service, you will be asked to either pay in full for services rendered or re-schedule your appointment for a time when you can bring the insurance card and/or referral.

DEDUCTIBLES AND CO-PAYMENTS WILL BE COLLECTED AT THE TIME OF THE VISIT, AND WE WILL BILL YOUR INSURANCE FOR THE BALANCE UNDER THESE PLAN PROVISIONS. AFTER YOUR INSURANCE PAYS AND THE INSURANCE COMPANY SAYS THAT YOU STILL HAVE A BLANCE, YOU WILL BE RESPONSIBLE FOR THE BALANCE WHICH IS DUE WITHIN 30 DAYS AFTER YOUR RECEIVE YOUR FIRST STATEMENT.

The majority of services rendered in this office are considered office surgery by your insurance company. This may result ion a higher co-payment or charges may be subject to a surgical deductible. As a result, you may be responsible for a higher co-payment, payment of surgical deductible and/or full payment of services rendered at the time of your visit.

If you understand and agree with this policy, please sign below.

Thank you,

Drs. McKinney, Cuza, Dagley, Moss and Cuza.

\_\_\_\_\_  
Patient's 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 chose) and understood the Notice.

\_\_\_\_\_  
Patient Name (please print)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent of Authorized Representative (if applicable)

\_\_\_\_\_  
Signature