For your convenience, and to simplify the billing process, our practice keeps credit cards securely on file. This is done to cover incidental charges, such as copayment, coinsurance, and deductible. Please present your driver's license, health insurance card, and a major credit card to the front desk to begin the registration process.

Date: ____________________

Patient's Name: **Sex:** □ M □ F

Last______________________ First_____________________ MI________

Age:_________ **Date of Birth:**_______________ **Social Security Number:** _________________

mm/dd/yy

Home Address:____

City:_________________________ State:__________ Zip:______________

Preferred Contact:

- □ Mobile Phone:_______________________________
- □ Home Phone: ______________________________
- □ Email:____________________________________

How did you hear about us?

- □ Google/Internet Search
- □ Existing Patient: ___________________________________
- □ Physician Referral: _________________________________

Who is your family doctor?

Primary Care Doctor: ______________________________ **Phone:** _________________________

What is your preferred pharmacy?

Pharmacy:_________________________________ **Location (Zip Code):**________________

Phone Number: _____________________________

Please provide an emergency contact (friend or family member) with which we can share your information:

Name: ____________________________ Relation:________________ Phone:_________________

Primary Insurance Information

Insurance Name: ____

Policy Number:_________________________ Group#_________________________________

Provider Services Ph#(Located on the back):____

Policy Holders Name:____

Policy Holders DOB:___________________

Policy Holders Address:____

Secondary Insurance Information

Insurance Name: ____

Policy Number:_________________________ Group#_________________________________

Provider Services Ph#(Located on the back):____

Policy Holders Name:____

Policy Holders DOB:___________________

Policy Holders Address:____

Allergies: **□ No Allergies or adverse reactions**

□ Medication (specify)
□ Anesthesia
□ Food/Shellfish
□ Iodine
□ Tape
□ Latex

Other Allergies:____

Past Medical History **□ No Past Medical History or Conditions**

Condition	Yes	No	Condition	Yes	No	Condition	Yes	No
Anemia	□ Yes	□ No	Heart Attack (MI)	□ Yes	□ No	Pacemaker	□ Yes	□ No
Anxiety Disorder	□ Yes	□ No	Heart Disease/Failure	□ Yes	□ No	Peripheral Vascular	□ Yes	□ No
Arthritis	□ Yes	□ No	Heart Problems	□ Yes	□ No	Pneumonia	□ Yes	□ No
Asthma	□ Yes	□ No	Hepatitis	□ Yes	□ No	Polio	□ Yes	□ No
Bleeding Disorder	□ Yes	□ No	Hernia	□ Yes	□ No	Pulmonary Embolism	□ Yes	□ No
Blood Clot	□ Yes	□ No	Hypertension	□ Yes	□ No	Rheumatoid Arthritis	□ Yes	□ No
Cancer	□ Yes	□ No	Kidney Disease	□ Yes	□ No	Seizures/Epilepsy	□ Yes	□ No
Coronary Artery Dis.	□ Yes	□ No	Leg or Foot Ulcers	□ Yes	□ No	Stroke	□ Yes	□ No
Depression	□ Yes	□ No	Liver Disease	□ Yes	□ No	Stroke	□ Yes	□ No
Diabetes	□ Yes	□ No	Lung Disease	□ Yes	□ No	Thyroid Problems	□ Yes	□ No
GERD/Reflux	□ Yes	□ No	Migraines	□ Yes	□ No	Tuberculosis	□ Yes	□ No
Gout	□ Yes	□ No	Neuropathy	□ Yes	□ No	Ulcers	□ Yes	□ No
HIV or AIDS	□ Yes	□ No	Osteoporosis	□ Yes	□ No	Urinary Tract Infection	□ Yes	□ No

Other Conditions:____

Review of Systems: (Please ✔ if your currently have any of these symptoms)

Cardiovascular

__leg pain when walking
__chest pain
__cold hands or feet
__leg swelling
__chest pressure/angina

General

__nausea
__fever
__vomiting
__chills
__weight gain or weight loss

Hematologic

__sickle cell disease
__clotting disorder
__anemia
__bleeding problems
__use of blood thinners

Genitourinary

__currently pregnant
__kidney disease
__kidney stones

Integumentary

__athletes foot
__nail abnormalities
__keloids
__itchiness
__dry, scaly skin
__lower leg ulcers

Neurological

__tingling
__weakness
__seizers
__numbness
__tremors
__paralysis

Past Surgical History: ◻ **No Prior Surgeries or Hospitalizations**

Please list all prior surgeries and hospitalizations.

Surgery/Hospitalization: Date:

____
____
____
____
____
____
____

Medications: For improved prescription safety and for your convenience, we are able to download this information electronically from your pharmacy.

◻ **No Current Prescription Medications, over the counter Medicines, or herbal or dietary supplements**

Please list all current prescriptions, over the counter medications, and herbal or dietary supplements.

Medication Name: **Dose:** **How Often:**

____
____
____
____
____

Family History:

Marital Status:

◻ Single
◻ Partnered
◻ Married
◻ Separated
◻ Divorced
◻ Widowed

Do others depend upon you for their care? ◻ Yes ◻ No

◻ Children ◻ Elderly or disabled family member ◻ Other:____________________

Do you have a family history (mother, father, siblings) of:

◻ Cancer
◻ Diabetes
◻ Heart Disease
◻ High Blood Pressure
◻ Neurologic Disease
◻ Stroke
◻ Rheumatoid Arthritis
◻ Other:________________________________

Social History:

Employer:____
Occupation:____

What percentage of your workday is spent standing or walking?
□ 10% □ 25% □ 50% □ 75% □ 100%

Exercise: □ Never □ Occasional □ Weekly □ Daily

Alcohol: □ Never □ Occasional □ Weekly □ Daily

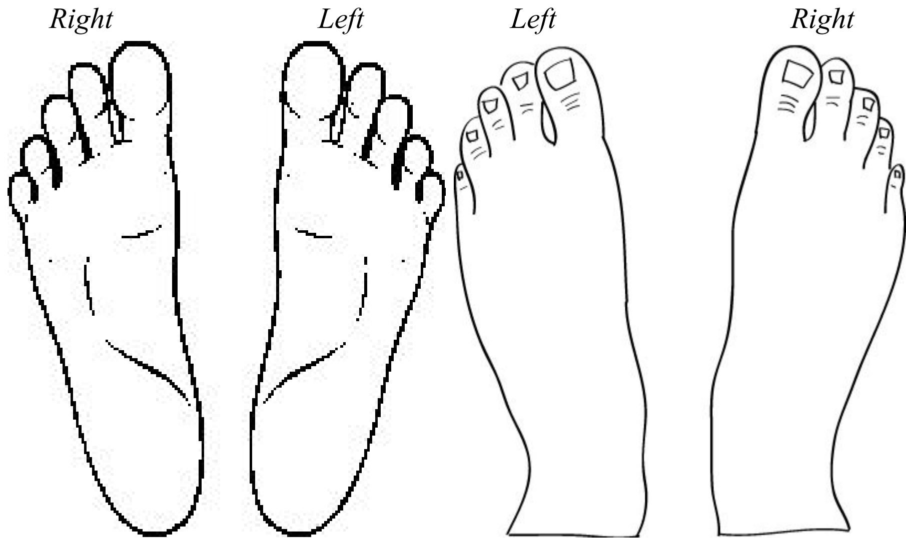
Tobacco: □ Never □ Quit: How Long Ago?________________

□ Smoke________ packs/day for ________years

Height / Weight: Please provide your height and estimated weight:
Height:______________________________ Weight:______________________________

Chief complaint:
What problem brings you to our office today?____

Where is the pain/problem located? Please mark on the pictures below.



How long ago did this problem start?____

Did your pain or problem begin: □ suddenly □ gradually

Was this problem caused by an injury? □ Yes □ No

If yes, was it a work-related injury? □ Yes □ No

If Yes, Please Describe:____

How would you describe your pain?

□ No Pain □ Sharp □ Dull □ Aching □ Burning □ Radiating

□ Other:____

How would you rate your pain on a scale from 0 to 10? (please circle)

0 1 2 3 4 5 6 7 8 9 10

(no pain) **(worst possible)**

Since your pain or problem began, has it: □ worsened □ improved □ remained unchanged

What makes your pain or problem feel worse?

□ Standing □ Walking □ Running □ Daily activities □ Dress shoes □ High heels

□ Other:____

What makes your pain or problem feel better?

□ Resting □ Ice □ Elevation □ Wrapping □ Massage

□ Other:____

What treatments have you had for this problem?____

How has this problem affected your lifestyle or ability to work?______________________________

Authorization and Assignment of Benefits

Acknowledgement of Notice of Privacy Practices (HIPAA): I understand that I am entitled to receive a copy of the notice of privacy practices, available upon request and on our website.

Completeness and Accuracy: I have answered the questions on this form accurately and to the best of my knowledge. I understand that providing incorrect information can be dangerous to my health. I understand that it is my responsibility to inform the doctor and office staff of any changes in my medical status.

Please be advised that by completing this form, we are not establishing a physician-patient relationship; The Doctor will review your health history and conduct an initial evaluation to determine whether you are a suitable candidate and whether the practice will accept you as a patient.

Treatment Authorization: I give consent to the Dr. Michael Krynski, DPM to perform office based medical procedures to treat my condition, symptoms, illnesses, or injuries. I also give the same consent for my minor child or children.

Medication History Authorization: I give consent to the Dr. Michael Krynski to access and download my prescription medication history.

Release of Medical Information and Assignment of Benefits: I authorize the release of all information necessary to submit, document, and process insurance claims on my behalf. I assign to Dr. Mihcael Krynski, DPM the payment and benefits of any and all health insurance and personal injury insurance policies to which I may be entitled.

Financial and Office Policies

I accept the Financial and Office Policies of Dr. Michael Krynski, a professional physician:

As a courtesy to our patients, the practice submits charges to contracted insurance plans. We are obligated to collect patient responsibility amounts such as co-payment, co-insurance, deductible, and any non-covered services at the time of service. Sometimes, exact coverage cannot be determined until the insurance company receives the claim.

To simplify billing, and for your convenience, the practice maintains credit cards securely on file. We will notify you prior to any charges being submitted to your card.

If services provided are determined by your health plan to be fully or partially non-covered for any reason, you agree to waive your contractual coverage and agree to be responsible for the complete charge.

Further, if for any reason, your health insurance company does not pay our office within sixty days, we will submit outstanding charges to the credit card on file.

Appointment Cancellation Policy: Patients who fail to arrive within fifteen minutes for their scheduled appointments or who cancel with less than 24 hours notice will be charged a fee of $25 to the credit card on file.

Surgery Cancellation Policy: A scheduling fee will be assessed on cancellations or rescheduling occurring less than seven days before the procedure

5 – 7 days before the procedure:	15% of the surgeon's fees
48 hours or less before the procedure:	$400.00

There are exceptions to the cancellation policy and these exceptions will be reviewed on a case by case basis.

Copy: An electronic copy of this agreement shall be binding as original.

Acceptance of our financial and office policy is mandatory in order to complete your registration, receive medical evaluation, and treatment.

___________________________________ ________________________

Patient Name (print) Date

___________________________________ ________________________

Signature of Patient/Legal Guardian Relationship (if applicable)

Authorization Agreement for Payment of Your Bill

This authorization is for the patient responsibility portion of your bill. For contracted insurance, this will be the amount remained after insurance payment and adjustment by your insurance company.
We acknowledge that the origination of transactions to your account must comply with the provisions of U.S. law.

Patient Name ____ Account # _______________
(Please Print)

Cardholder's Name ____
(If different from patient)

Credit Card # ______________ -- ______________ -- ______________ -- ______________

Expiration Date _______________________ Security Code __________________
(Month/Year) (Digit Code)

Type of Card: (Please circle one) MasterCard Visa Discover

I authorize Dr. Michael Krynski, DPM to keep my signature on file and to charge the credit card identified above for the balance of charges not paid by my insurance company 60 days or more following date of service. This is for all treatment provided for the above named patient.

Patients that are scheduled must leave a credit card on file or leave a cash payment of $150.00 prior to seeing the doctor.

No credit card charge will be made until 60 days or more following date of service.

I will be notified by billing staff or statement of any charges made to my credit card.

At any time, I may elect to pay my account in full to prevent this authorization from being activated.

I assign my insurance benefits to Dr. Michael Krynski DPM. I understand that this form is valid unless I cancel the authorization through written notice to Dr. Michael Krynski, DPM.

____ ____________________________
Cardholder Signature (If different from patient) Date

____ ____________________________
Patient Signature (Parent signature if under 18) Date