SUSZ PODIATRY & WOUND CENTERS

1 Timberview Lane,
Russell, PA 16345
814-757-8204 phone
814-757-8658 fax

305 E. Fairmount Avenue, Unit F
Lakewood, NY 14750
716-664-9698 phone
716-661-3851 fax

www.suszpodiatry.com

Thank you for choosing Susz Podiatry & Wound Centers

We are looking forward to helping you with your podiatric, surgical and wound care needs. Enclosed you will find a "New Patient Paperwork" packet. Please take time before your visit to read through and fill out each form. Bring this packet, along with your insurance cards, to your appointment. We ask that you arrive 15 minutes early so that the registration process goes smoothly.

The following are our office policies. By initialing each item, you are acknowledging that you understand and accept these policies.

1. **IN-NETWORK, OUT-OF-NETWORK BENEFITS**-IT IS YOUR RESPONSIBILITY AS THE PATIENT TO CONTACT YOUR INSURANCE PROVIDER TO VERIFY THAT SUSZ PODIATRY & WOUND CENTERS IS AN IN-NETWORK PROVIDER WITH YOUR POLICY. THE PHONE NUMBER TO CALL IS LOCATED ON THE BACK OF YOUR INSURANCE CARD. REFERENCE TAX ID 26-4328116WHEN SPEAKING WITH YOUR INSURANCE COMPANY.

   Other valuable information to obtain will be what your potential out-of-pocket costs may be such as copays, Co-insurances and deductible.

   Initials ____________

2. **Self-pay patients** – A minimum payment of $125.00 is to be paid in full at the time of service. Payment at each additional appointment, as well as any outstanding balance, will need to be kept current.

   Initials ____________

3. **No-show fee** – There will be a $25 fee for all missed appointments without a 24-hour notice.

   Initials ____________

4. **Paperwork Fees**- FMLA Forms-**$25.00 per request**
   All Other Forms-**$5.00** (Disability, Handicapped Parking, etc.)
   Chart requests (other than provider-to-provider)-**$25.00 per chart**

   Initials ____________

5. **Returned Check Fee**- There will be a $**50.00** fee for all returned checks.

   Initials ____________

We want your experience with us to be a positive one. If you have any questions or concerns, please feel free to contact our office and we will be glad to help.

Sincerely,

Susz Podiatry & Wound Center Staff

*****IMPORTANT*****

IN-NETWORK / OUT-OF-NETWORK BENEFITS

It is YOUR responsibility as the patient to contact your insurance provider to verify Susz Podiatry & Wound Centers is an in-network provider with your policy/plan. The phone number to call is located on the back of your insurance card. Reference our Tax ID 26-4328116 when speaking with your insurance company.

Other valuable information to obtain will be your potential out-of-pocket costs such as copays, coinsurances and deductibles.

By signing, you acknowledge you have contacted your insurance company. Additionally, you are responsible for any and all charges not covered by your insurance, i.e. copays, coinsurances, deductibles and out-of-network charges.

_______________________________ _______________

Signature **Date**

IMPORTANT

SUSZ PODIATRY & WOUND CENTERS

John H. Susz, DPM, FACFAS
Podiatric Medicine, Surgery, and Wound Care

Patient Intake Form

Demographic Information

Patient Name____ Address ____

Birth date ____/____/___ SSN ________________ City _________________________ST_____ Zip________

□Male □Female Marital Status: S M D O W Home Phone ____________________________________

Occupation ___________________________________ Work Phone _____________________________________

Employer ___________________________________ Cell Phone ______________________________________

May we leave messages regarding test results? □ Yes □ No

Languages: □ English □Spanish □ Other Ethnicity: □ Hispanic □ Latino □ Not Hispanic or Latino

Race: □ White □ Black or African American □American Indian □ other □ Unknown □ Decline to Specify

Email Address for Portal ____

Emergency Contact (name and phone #) ____

How did you hear about us? ______________________________ If referred, by whom? _________________________________

Physician Information

Referring physician _______________________________________ Phone _________________ Fax _______________

Primary care physician ___________________________________ Phone _________________ Fax _______________

Date last seen by Primary Care Physician ____

Pharmacy: ____Phone:____________________________________

Primary Insurance ______________________________

Subscriber name ______________________ ID# _____________________ Group # ________________

Subscriber birth date ___________________ Claims Address ___________________________________

Subscriber SSN _______________________ Claims Phone # __________________________________

Relationship to patient __________________ Employer____

Secondary Insurance ____________________________

Subscriber name ______________________ ID# ____________________ Group # ________________

Subscriber birth date ___________________ Claims Address ___________________________________

Relationship to patient __________________ Claims Phone # __________________________________

Employer________________________________

I hereby authorize the release of any medical or other information necessary to process this claim. I also authorize payment of medical benefits to the supplier for services rendered. I further agree that should the amount be insufficient to cover the entire medical expenses, I will be responsible for payment.

Signed ____ Date _____/_____/_____

Please describe what brings you to our office today?

____

____

____

____

____

Do you have pain? _______ Pain Scale: mild 1 2 3 4 5 6 7 8 9 10 Severe

How would you describe your pain? Check any of the following that apply.

__Sharp __aching __throbbing __shooting __electrical sensation __burning __pins & needles

Other:____

____

Location of pain or primary complaint:

__lower leg __ankle __Achilles tendon __heel __midfoot __arch __forefoot
__sole of foot __ball of foot __top of foot __big toe __lesser toes __toenails

How long has your problem been present?

__1-3 days __3-7 days __1-3 weeks __4-8 weeks __3-6 months __6-9 months __9-12 months
__Greater than 1 year

Have you attempted any treatments to relieve your problems? Check any of the following that apply.

__rest __ice __elevation __stretching

__change shoe gear

__trimming out toenail yourself

__treated by another physician

__applying skin cream

__over the counter padding/inserts/orthotics

__surgery for this condition by another physician

__applying antibiotic ointment (Bacitracin, Neosporin)

__over the counter anti-inflammatory medication (Motrin, Tylenol, Aspirin)

Additional information: ____

Patient name________________________ Date__________

Past Medical History: Check all that apply

__ Hypertension/High Blood Pressure
__ Neuropathy
__ HIV
__ Gout
__ Non-Insulin Dependent Diabetes
__ Heart Attack
__ Asthma
__ Back Pain
__ Insulin Dependent Diabetes
__ Heart Murmur
__ Emphysema
__ Ulcer
__ Congestive Heart Failure
__ Osteoarthritis
__ High Cholesterol
__ Stroke
__ Leg Pain with walking
__ Leg Pain at Rest
__ Blood Clots/DVT
__ Cancer

PLEASE LIST OTHER MEDICAL HISTORY BELOW:

____
____
____

Past surgical History: have you had any of the following surgeries?

__ Heart Bypass
__ Hysterectomy
__ Gallbladder
__ C-section
__ Tonsils
__ Appendectomy
__ Joint Replacement
__ Heart Valve Repair or Replacement

PLEASE LIST ANY OTHER SURGERIES:

____
____
____

Family History: PLEASE LIST WHO IN FAMILY (mother, father, sister, brother) .PLEASE INDICATE IF THEY ARE LIVING OR DECEASED.

__ Diabetes__________ Stroke_____________ Heart Attack_________ Cancer_______
__Other____
____

Social History:

Do you drink alcohol? **PLEASE CIRCLE YES OR NO.** If yes, please answer the following:
__ Daily __ Occasional drinking only __ History of alcoholism

Do you smoke or have you ever smoked? **PLEASE CIRCLE YES OR** NO If yes please answer the following:

How many years have you smoked? _________ How many packs per day? ___________
If you quit smoking, how many years ago did you quit? _____________

Do you use any recreational drugs? **PLEASE CIRCLE YES OR NO**. If yes please list below
____

Caffeine (how much per day) _______________________________________

Patient name_________________________ Date___________

Medications: **PLEASE LIST ANY AND ALL MEDICATIONS AND DOSAGE**

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Allergies: Do you have allergies to any of the following? ***Please include reaction*** Check all that apply

__penicillin __erythromycin __adhesive tape __sulfa __codeine

__aspirin __cortisone __local anesthetics __iodine __latex

Other allergies:

Please list: ____

____

____

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____

____

____

Height_______ Weight______ Shoe size/width____________

For Office Use:

Temp________ Pulse____________ Resp. _______________ BP_________________

Patient name_______________________ Date__________

SUSZ PODIATRY & WOUND CENTERS
John H. Susz, DPM, FACFAS
Podiatric Medicine, Surgery, and Wound Care

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE

I acknowledge that I understand the privacy laws of
Susz Podiatry & Wound Centers
Notice of Privacy Practices.

Patient Signature: ____

Date: ______________________________________

OR

Signature of Personal Representative: ______________________________________

Relationship to the Patient: ____

Date: ____

Please list below the following person or persons we are able to discuss your medical appointments and treatments with.

No one but myself (Please circle if this applies)

____Relationship______________

____Relationship______________

____Relationship______________

____Relationship______________

____Relationship______________

____Relationship______________

Patient name___________________________ Date___________

SUSZ PODIATRY & WOUND CENTERS
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Podiatric Medicine, Surgery, and Wound Care

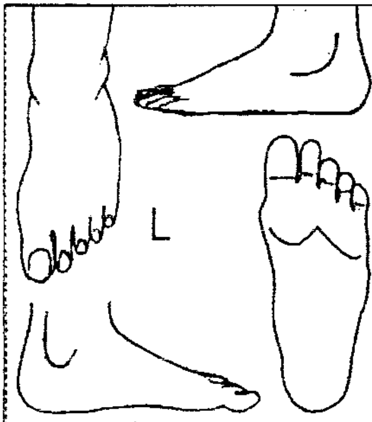
Physical Examination

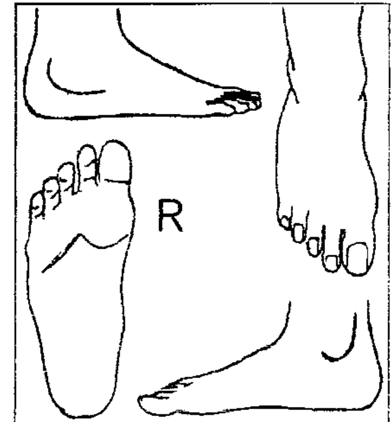
Vascular:
Pedal Pulses: DP_______L_______R PT______L______R CFT______L______R
Skin Temperature: ____________________________ Skin Turgor/Texture: _________________________
Edema: ______________________________________ Hair Growth: _______________________________
Elevational Pallor: _____ Dependant Rubor: _____ Hohman's Sign_______________________________
Telangiectasias: _______________________________ Varicose Veins: _____________________________

Dermatological:
Nails: TA T1 T2 T3 T4 T5 T6 T7 T8 T9 Pathology____
Hyperkeratotic Lesions: ____
Ulcerations: ____
____
____

Neurological:
Tinnel's: ____________________________________ SW 5.07 MF: ________________________________
Vibratory: ___________________________________ Proprioception: ______________________________
Plantar Response: _____________________________ Clonus: _____________________________________
Reflexes: Knee _______L _______R Ankle _______L_______R Muscle Strength:____________________

Musculoskeletal: Left Right
Ankle: (Ext) __________ (Flex) __________ (Ext) _________ (Flex) _________
Quality_____________________________ Quality____________________________
STJ: Inv.___________ Ever.__________ Inv.__________ Ever.__________
Quality____________________________ Quality____________________________
Foot Type: Rectus Cavus Pes Planus Gait Eval:____________________________________
FF vs. RF: valgus neutral varus valgus neutral varus
RCSP: valgus neutral varus valgus neutral varus
Single Heel Raise: __________________________ ____
1st MTPJ: hypermobility trackbound crepitus hypermobility trackbound crepitus
Spurring _______ROM: ___________________ spurring____________ ROM: ___________
____
Lesser MTPJ: ______________________________ ____
Digital Deformities: __________________________ ____
____





Patient name____________________________ Date____________________

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Equipment: Orthotics Custom / OTC / Diabetic ____________________Shoes ____________________________
Sneakers____________________________ Boots Sandals Flip Flops Other____________________________
Braces______________________________ Wheelchair Crutches Walker Cane___________________________

Clinical Pathology:
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Radiographic:
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Impression:
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Plan:
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Signature______________________Date______________