JEREMY BIER, D.P.M., FACFAS
Board Certified, American Board of Foot and Ankle Surgery
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Patient Information

Date: _____

First Name: _____ Middle Initial: _____ Last Name: _____

Address: _____ Apt#:_____

City: _____State:_____ Zip Code: _____

Home Phone: _____ Mobile Phone: _____

Email Address: _____

DOB: _____ Gender: _____

Employers Name: _____ Work Phone: _____

Spouses Name: _____Employer:_____

Spouses Work Phone: _____

If Patient is a minor, who is responsible for the patient? _____

How did you hear about us? Dr. _____Google/Internet_____

Facebook _____Insurance Website _____Family/Friend_____

Primary care physician's name and address: _____

Preferred Pharmacy Name and Address: _____

Name and Telephone number of person to call in an emergency:

_____

Medical History:

Reason for today's visit: _____

_____

Do you have any medical problems or conditions? _____

_____

_____

Please list ALL current medications, including over the counter, supplements, and herbs:

Medication Name	Dose

Please list any past surgeries and hospitalizations and the approximate date:

Procedure/Hospitalization	Date	Reason	Complications

Do you have any allergies to medications or other substances (pets, plants, food, etc.)? YES/NO

If yes, please list allergies and reactions (including rash, hives, throat swelling, and anaphylaxis):

Allergy	Reaction

Height: _____Weight: _____Shoe Size: _____

Have you EVER had any of the following?

Anemia/Bleeding tendency	Y	N	Ear/Nose/Throat	Y	N
Asthma/Breathing problems	Y	N	Eczema/Skin disorder	Y	N
Behavioral problems	Y	N	Eye disorder	Y	N
Blood transfusion	Y	N	Growth disorder	Y	N
Bowel/Stomach problems	Y	N	Heart disorder/defect	Y	N
Cancer/Leukemia	Y	N	Kidney/Bladder problem	Y	N
Shingles	Y	N	Liver disease	Y	N
Diabetes	Y	N	Seizure or Epilepsy	Y	N
COVID-19	Y	N	Thyroid disorder	Y	N

Please list any other medical illnesses or problems and provide details for any of the above conditions:

_____

_____

Patient Family History:

Please indicate any major conditions/illnesses that the patient's immediate family members have had:

Relative	Condition	Living?	If deceased, at what age?
Parent:		Y/N	
Parent:		Y/N	
Sibling:		Y/N	
Other:		Y/N	

Patient Social History:

Do you smoke? YES---NO ---NEVER. If yes, packs/day_____
If no, previously? YES---NO Years smoked_____ Packs/day_____
Do you use other tobacco products? YES---NO
Consume alcohol? YES---NO. If yes, drinks/week_____

Review of Systems

Please indicate ALL that the patient has experienced within the past 6-12 months.

Constitutional

Fever	Y	N	Fatigue	Y	N	Weight. Gain (_____Lbs.)	Y	N
Chills	Y	N	Feeling Poorly	Y	N	Weight Loss (_____Lbs.)	Y	N
Sweats	Y	N	Sleep Disturbances	Y	N	Other_____ _____		

Cardiovascular

Chest Pain	Y	N	Cold Extremities	Y	N	Irregular Heart Rhythm	Y	N
Palpitations	Y	N	Cold Hands or Feet	Y	N	Other	Y	N
Leg Swelling	Y	N	Leg Pain with Walking	Y	N			

Respiratory

Shortness of Breath	Y	N	Wheezing	Y	N	Coughing up Blood	Y	N
Cough	Y	N	Chest Congestion	Y	N	Other:		
Rapid Breathing	Y	N	Coughing up Sputum	Y	N			

Gastrointestinal

Abdominal Pain	Y	N	Diarrhea	Y	N	Change in Bowels	Y	N
Blood in Stool	Y	N	Black/Tarry Stools	Y	N	Vomiting Blood	Y	N
Vomiting	Y	N	Decreased Appetite	Y	N	Bowel Incontinence	Y	N
Nausea	Y	N	Yellow Skin	Y	N	Heartburn	Y	N
Constipation	Y	N	Trouble Swallowing	Y	N	Other:		

Review of Systems Continued

Neurological

Headache	Y	N	Poor Coordination	Y	N	Numbness	Y	N	Tremor	Y	N
Dizziness	Y	N	Disorientation	Y	N	Tingling	Y	N	Memory Lapses/Loss	Y	N
Unsteady	Y	N	Decreased Strength	Y	N	Seizures	Y	N	Other:		
Confusion	Y	N	Burning Sensation	Y	N	Fainting (Syncope)	Y	N			

Musculoskeletal

Joint Pain	Y	N	Limb Pain	Y	N	Muscle Pain	Y	N
Neck Pain	Y	N	Joint Swelling	Y	N	Muscle Weakness	Y	N
Back Pain	Y	N	Muscle Cramps	Y	N	Leg Swelling	Y	N

Integumentary

Rash	Y	N	Skin Wound	Y	N	Unusual Growth	Y	N	Skin Cancer	Y	N
Dry Skin	Y	N	Change in a Mole	Y	N	Itching	Y	N	Other:		

Psychiatric

Depression	Y	N	Anxiety	Y	N	Other:

Hematologic/Lymphatic

Easy Bruising	Y	N	Easy Bleeding	Y	N	Swollen Lymph Nodes	Y	N	Other:

Endocrine

Excessive Thirst	Y	N	Heat Intolerance	Y	N	Skin Changes	Y	N
Cold Intolerance	Y	N	Hair Changes	Y	N	Other:		

OFFICE USE ONLY:

Provider Signature: _____Date: _____

Office Policy and Financial Agreement:

Dr. Bier and his office staff are committed to providing you with exceptional care. Your clear understanding of our office policy is important to our professional relationship. Please ask us if you have questions about our fees, financial policy or your financial responsibility.

We will need a copy of your insurance cards for our files. If you do not have it at the time of your visit you will be responsible for payment at the visit. This is due to the short time frame most insurance companies have for filing a claim.

Co-Payments: By insurance policy rules we **MUST** collect your co-payment at the time of the visit. **Should you not pay at the time of service, you will receive a statement from our biller, and an administrative fee of$10.00 will be charged to you.**

Office Policy and Financial Agreement Continued:

Referrals: The insurance companies which utilize referrals have become strict about their use. Referrals are being processed electronically and cannot be back dated. **This means that you must have the referral at the time of your visit, or your credit card will be charged for all cost associated with your care at the time of the visit.**

Please be aware that most insurance companies have a 90 day filing period for claims, if we are not notified of any changes at the time of service (new insurance company, subscriber ID numbers, group numbers etc.) and the time limit has passed for filing of your claim; you will be responsible for all balances not paid by your insurance company.

Self-Pay Patients: Payment is expected at the time of service unless other arrangements have been made prior to your visit. Should you not pay at the time of service, you will receive a statement from our biller and an administrative charge of$10.00 will be charged to you.

Medicare: We will submit claims to Medicare. Patients will be responsible for any deductible and co-insurance balances.

Return Checks: There is a $25.00 fee for all checks being returned to us.

There is a .75 cents per page charge for copies of medical records plus postage. There is a $10.00 charge for copies of x-rays place onto a disc.

Appointments: 24 hours' notice would be appreciated for any cancellations.

You are responsible for the timely payment of balances. It is your responsibility to notify us as soon as possible of any insurance plan changes or home address information etc. Thank you for taking time to review our policies. Please feel free to ask any questions or share with us special concerns.

I understand that all applicable copayments and deductibles are due at the time of service. I agree to be financially responsible and make full payment for all charges not covered by my insurance company. I authorize my insurance benefits be paid directly to Preferred Footcare, LLC or its doctors for services rendered. I authorize representatives of Preferred Footcare, LLC to release pertinent medical information to my insurance company when requested or to facilitate payment of a claim.

Patient Portal Sign Up

Access your personal records securely, 24/7, on a computer, smartphone, or tablet.

I read and agree to all the above (Portal Sign Up, Insurance Information, and Financial Agreement).

Patient or Legal Guardian Name (Print): _____

Patient or Legal Guardian Signature: _____Date: _____

***Please refer to our website, STAMFORDFOOTCARE.COM, for a list of insurances accepted by your provider.**

CREDIT CARD ON FILE AUTHORIZATION:

Due to increasing high deductible plans, we are requiring all patients to store a credit card on file with us. We will not charge your card until after your claim has been processed by your insurance company and they determine what your portion is to us. Any remaining balance owed by you will be charged to your credit or HSA card and a copy of the charge will be mailed to you.

Name as it appears on the credit card: _____

Card Number: _____

Expiration Date: _____/_____ (MM/YYYY) Security Code: _____ (3- or 4-digit code)

Billing Zip Code: _____

By signing below, I authorize Preferred Footcare, LLC/Dr. Jeremy Bier to charge any outstanding balances due on my account after my insurance pays. I understand this charge is my responsibility.

Signature: _____Date:_____

Patient Preferred Method of Communication

To All of our Patients:

To communicate with our patients effectively, it is our policy to leave a message confirming appointments. It is our office policy NOT to leave any medical information or results in a telephone message without your permission. We do this in order to comply with medical confidentiality regulations.

Please indicate below whether we have your permission to speak with a family member or to leave a message on your answering machine/voicemail.

I hereby give permission for Dr. Jeremy Bier to:

1. Give information regarding test results, medical history, medications or billing

   To (name) _____phone#_____

2. Leave test results on my answering machine/voicemail: circle one: Yes No

Patient or Legal Guardian Name (Print): _____

Patient or Legal Guardian 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 or Legal Guardian Name (Print): _____

Patient or Legal Guardian Signature: _____Date: _____

I have the right to revoke this consent, in writing at any time, except to the extent that Jeremy A. Bier, D. P.M. has taken reliance on this consent.

This section to be completed by Jeremy A. Bier, D.P.M., if unable to obtain written acknowledgement from patient.

I made a good faith effort to obtain a written of acknowledgement of receipt of the Notice of Privacy Practices from the above patient, but was unable to because:

Patient declined to sign this written acknowledgement.

Other (specify)

_____

_____

_____

Name and Title of Employee_____Date: _____