Dear New Patient,

We would like to take this opportunity to welcome you to our practice and to thank you for choosing our providers to participate in your healthcare. We look forward to providing you with personalized, comprehensive health care focusing on wellness and prevention. As continuity and coordination of patient care is essential in meeting your healthcare needs, our doctors, medical assistants, and office staff will work closely in a "team approach" to support your patient care. Our normal office hours are **Monday-Tuesday 8am-4pm**, **Wednesday 8am-3pm**, **Thursday 8am-4pm** and **Friday 8am-3pm** (these times are subject to change if needed). Please note that we are available every day and will do our best to accommodate you. Booking an appointment is essential to ensuring all patients receive the time they desire for quality medical care.

If you need to cancel or reschedule your appointment, please attempt to contact the office 24 hours before your appointment. Same day cancellations will result in a $50 fee. However, we do understand some circumstances will result in you calling the same day. At that time, we will kindly reschedule or cancel accordingly. If you are to "no call no show" to your scheduled appointment, we will allow a 48-hour time for you to reach out to us to reschedule and provide the reason that kept you from your appointment. Once information is received, the doctor will make the better judgement as to charge the fee or not.

Please fill out the enclosed forms and bring them with you to your appointment. During your initial visit, we will be reviewing your health status and these forms that contain information necessary to complete this process. Please bring your **health insurance identification card** as well as a **photo I.D.** and complete list of all your medications (if applicable), as well as the strength and dose of each one.

Once again, we would like to thank you for choosing us for your podiatry needs. We look forward to working with you.

Sincerely,

The Providers and staff of Premier Podiatry

PREMIER PODIATRY

Dr. Steven Frank, DPM
Dr. Christopher Forsbach, DPM
12855 N Forty Dr. Ste. 175
St. Louis, MO 63141
Phone: 314-434-9600 Fax: 314-434-9601

PREMIER PODIATRY

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Name:_____ **DOB**:____/____/____.

Sex: ☐ M ☐ F **Marital Status**: ☐ Single ☐ Married ☐ Widowed ☐ Divorced Spouse:_____.

SSN:_____-_____-_____ **Email**:_____.

Address:_____ **City**:_____ **State**:_____ **Zip**:_____.

Cell:_____ Home:_____ Work:_____.

Ethnicity: ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or Pacific Islander ☐ White ☐ Hispanic ☐ Other ☐ Decline to Specify

Age:_____ **Height**:_____ **Weight**:_____ **Shoe Size**:_____.

Preferred Language?_____.

Are you employed? ☐ Yes ☐ No ☐ Retired If yes, Employer:_____.

Position:_____.

What is your activity level at work? ☐ Sedentary ☐ Moderate Activity ☐ Heavy Labor

Primary Care Physician:_____.

Phone:_____ **Date Last Seen**:_____/_____/_____.
MM DD YYYY

Were you referred? ☐ Yes ☐ No If Yes, who referred you?

☐ Google ☐ Pedicure Plus ☐ Facebook ☐ Other:_____.

If you were not referred, how did you hear about us?_____.

Emergency Contact Name:_____ **Phone**:_____.

Relationship to Patient:_____.

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Primary Insurance:_____.

Policy Holder Name:_____DOB:_____/_____/_____.

Relationship:_____Phone:_____.

Employer:_____SSN:_____.

Address:_____City:_____State:_____Zip:_____.

Member ID#:_____Group#:_____Phone:_____.

Secondary Insurance:_____.

Policy Holder Name:_____DOB:_____/_____/_____.

Relationship:_____Phone:_____.

Employer:_____SSN:_____.

Address:_____City:_____State:_____Zip:_____.

Member ID#:_____Group#:_____Phone:_____.

Social History:

(Only for Women) Are you Pregnant? ☐Yes ☐No If Yes, What is your due date?_____/_____/_____.

Do you smoke tobacco? ☐Yes ☐No ☐Former If Yes, How many a day?_____How many Yrs?_____.

If Former, How long ago did you stop?_____.

Do you ever use recreational drugs? (*This will in no way affect your relationship with the doctor and will be held in the most strict patient-doctor confidentiality)* ☐Yes ☐No If Yes, what kind and how often?_____.

_____.

Do you drink alcohol? ☐Yes ☐No If Yes, How much (per week, month, or year) and what kind (Wine, Beer, Hard Liquor, etc)?

_____.

Date of Last Physical:_____/_____/_____.

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Pharmacy Name:_____ **Phone**:_____.

Pharmacy Address:_____.

Medication	Dosage (Mg, Unit, etc)	How often taken?	What is it taken for?

What is the reason for your visit? (*Please be as specific as possible*)_____.

_____.

_____.

When did you first notice the issue?_____.

Did this result from an injury? ☐ Yes ☐ No If Yes, when did the injury occur?_____/_____/_____.

Was it work related? ☐ Yes ☐ No On a 0 to 10 scale (0=no pain, 10=worst pain) how bad is it?_____/10

Describe your pain: ☐ Sharp ☐ Shooting ☐ Achy ☐ Dull ☐ Numbness

When is it painful?_____.

Have you tried any previous treament? _____.

How has this affected your daily routine?_____.

Have you seen a podiatrist before today? ☐ Yes ☐ No If Yes, by whom and why?_____.

_____.

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Family History: (*Please mark F for Father or M for Mother or B for Both; This is ONLY for your blood relatives; If they have/had cancer please list what type of cancer.*)

Alzheimer's_____ Depression_____.

Arthritis_____ Diabetes_____.

Bleeding Disorder_____ Emphysema_____.

Blood Clot_____ Heart Disease_____.

Cancer _____ High Blood Pressure_____.

Cataracts_____ Neurological_____.

Circulation Problems_____ Strokes_____.

Other: _____.

Mother Alive? ☐Yes ☐No Father Alive? ☐Yes ☐No

Surgical History:

Procedure	Date	Complications

Have you been hospitalized other than surgery? ☐Yes ☐No If Yes, for what? _____.

_____.

Have you ever had injury to a lower extremity? ☐Yes ☐No If Yes, please explain:_____.

_____.

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Please list any allergies and reactions below (*If food or environmental please specify*):

If you have no allergies, please put NONE in the first box.

Examples: Penicillin, Sulfas, Iodine, Aspirin, Anesthetics, Latex, Codeine, Demerol, Cortisone

Allergies	Reaction

Patient Medical History: (*Please check any of the following that apply*)

☐ AIDS (HIV)	☐ CVA	☐ Glaucoma	☐ Kidney Disease	☐ Tuberculosis
☐ Anxiety Disorder	☐ Depression	☐ Gout	☐ Lung Disease	
☐ Arthritis	☐ Diabetes	☐ Heart Attack	☐ Neuropathy	
☐ Asthma	☐ DVT	☐ Heart Disease	☐ Osteoporosis	
☐ Bi-Pap/C-Pap	☐ Ehlers-Danlos	☐ Heartburn/Reflux	☐ Rheumatoid Arthritis	
☐ Blood Clots	☐ Epilepsy	☐ Hepatitis	☐ Skin Disorder	
☐ Blood Disorder	☐ Factor V	☐ High Blood Pressure	☐ Stroke	
☐ Circulation Problems	☐ Fibromyalgia	☐ High Cholesterol	☐ Thyroid Disease	

☐ Other_____.

☐ Cancer (*and what type*)_____.

Arthritis Type (If not listed above):_____.

If you are diabetic: What was your last A1C?_____.

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Opioid Treatment Agreement:

In the event of Premier Podiatry prescribing an opioid medication for treatment of pain:

1) I understand:
    a. I will inform my doctor if I have/had a substance abuse problem.
    b. I will only take the dose/frequency as prescribed by the doctor.
    c. I will not request opioids/other pain meds from other doctors.
    d. I will inform doctor of other meds I am taking.
    e. I will not share my scripts with anyone and will keep them away from children. If the meds are lost or stolen I understand it will not be replaced.
2) I understand Opioids are highly addictive and if I believe I have a problem I will seek help.
3) I realize the potential danger associated with the use of opioids, especially when driving/operating heavy equipment, such as side effects of slow reaction time, clouded judgement, and drowsiness.
4) I understand if my pain exceeds a three-week treatment period of narcotic medications, Premier Podiatry may refer me to a Pain Management Center.

I have read, understood, and have had all my questions answered satisfactorily. If prescribed, I consent to the use of opioids to help control pain.

Signature:_____ Date:_____/_____/_____.

Guardian Signature:_____ Date:_____/_____/_____.

Consent to Release Health Information: (*Only select one or the other*)

I (Print Name)_____ hereby give my consent to Premier Podiatry to disclose the following Protected Health Information to the individuals listed below.

I (Print Name)_____ hereby **do not** give my consent to have Premier Podiatry disclose any Protected Health Information to any individuals.

Please check the information allowed for release to the individuals:

☐All Procedures ☐Test Results ☐Appointments ☐Other ☐Surgeries ☐Billing/Account Information

Name	Relationship

Signature:_____ Date:_____/_____/_____.

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Financial/Privacy Policy

We participate in most insurance plans and knowing your insurance benefits is your responsibility. If you are not insured by a plan we can serve you as a self-pay visit but payment in full will be due at each visit in office. If you're insured by a plan we participate with but do not have an up-to-date insurance card, then payment will be treated as self-pay until coverage is verified. We will run your insurance and any secondary insurance for the visit. However, any balance not covered by insurance is the patient's responsibility. All co-payments and deductibles must be paid at the time of service by Cash, Check, or Credit Card. There are some services and items that may not be covered by Medicare or other insurers. These will therefore become self-pay and payment due upon service or delivery of item.

You will be sent three notices regarding your outstanding balance after payment and/or explanation of benefits (EOB) is received from your insurance company/companies. After the third notice, your account will be forwarded to collections. Please notify the billing office if you are unable to pay your bill in full. Payment arrangements may be available. An Additional $25.00 will be added to your statement if the check is returned for insufficient funds. In the event that your insurance company sends payment directly to you, it should be forwarded to our office to be applied to your balance.

Appointment Cancellation Policy

- Our office requires a **24-hour notice** in the event you need to reschedule your appointment; this will allow us the opportunity to provide care to another patient.
- **Without proper 24-hour notification** you will be assessed a $50 fee to reschedule your appointment. A message may be left to avoid a cancellation fee.
- This fee is not billable to your insurance.
- Repeated missed appointments may result in termination of the physician/patient relationship.

HIPPA Policy

Any information disclosed in your records will remain confidential and will not be used for any other reason except in providing quality care and treatment, releasing information to requested physicians for further care, or in the case of submitting a claim to your insurance company.

I hereby understand my financial responsibility and the information on the Policies provided above. By signing below, I am consenting to the Policies above as provided by Premier Podiatry.

Signature:_____ Date:_____/_____/_____.

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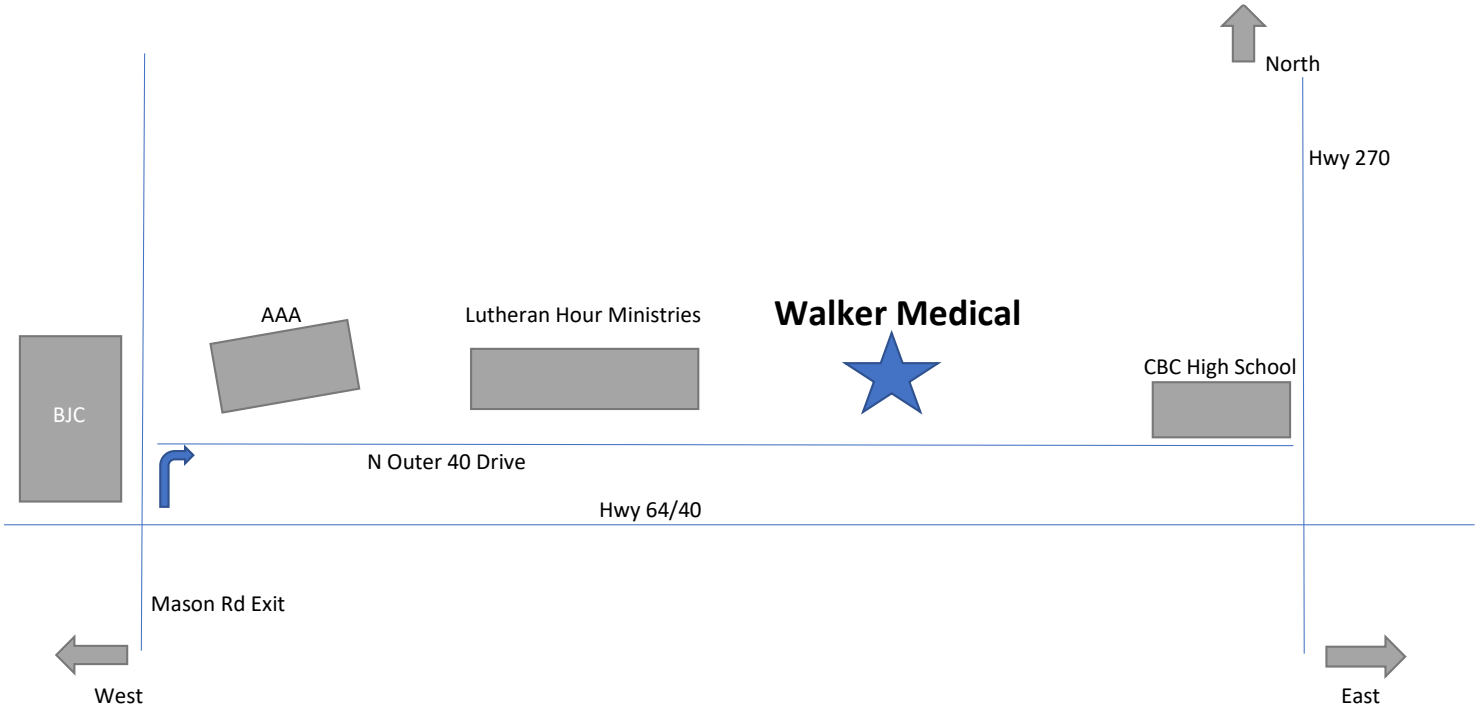

Premier Podiatry

Walker Medical Building, South Tower

12855 N Forty Dr. Suite 175

St. Louis, MO 63141

Phone # (314) 434-9600