Thank you for choosing Dr. Hoffman & Associates, P.A.

You can help make our registration process faster and more efficient by completing the enclosed forms and returning them with you at the time of your appointment.

Please carefully fill out the insurance portion on the attached form.

➢ Please be sure to sign where indicated on all forms.
➢ We do file insurance automatically as a courtesy to you.
➢ We request that you bring your insurance card(s) with you so that we can make a copy of them for our records.
➢ If you need a referral for insurance, please arrange that referral prior to your first visit.
➢ Motor vehicle accident and/or public liability:
   ❖ It is your responsibility to have the billing and/or insurance information completed on the form and should accompany you to your first appointment.

X-rays, MRI’s, CT scans, Bone scans, etc:

➢ Please remember to bring all films and/or reports with you to your appointment.

Medical Records:

➢ Please either hand carry or forward to our office any outside medical records pertaining to the podiatric problem(s) you are going to be seen for.

Medications:

➢ Please remember to bring a list of all medications with you to your appointment.

PLEASE PROVIDE 24 HOUR NOTICE OF CANCELLATION IF YOU ARE UNABLE TO KEEP APPOINTMENT.

PLEASE ARRIVE 15 MINUTES PRIOR TO APPOINTMENT TIME TO COMPLETE REGISTRATION. FORMS MUST BE COMPLETED PRIOR TO CHECK-IN OR APPOINTMENT WILL BE RESCHEDULED.

A $50 NO SHOW FEE WILL BE CHARGED.

APPOINTMENT DATE: ___________________________ TIME: _______________
Dr. Hoffman and staff value the trust that you place in us to provide your care. Your clear understanding of our financial policy is an important part of our professional relationship. Please make sure to ask if you have any questions about our fees, our policies or your responsibilities.

**Prior to your appointment you will be required to complete our Patient Information Forms. This needs to be completed before you see the physician.**

**INSURANCE**

Please present with a photo ID and your insurance card at each visit.

It is the **patient’s responsibility** to **provide current insurance information** to the billing office.

It is **your responsibility** to call your insurance company to make sure we are in your network. Referrals, if required, from your medical doctor need to be provided before you see your physician.

Your insurance policy is a contract between you and your insurance carrier. We file insurance as a courtesy to you and will help you in any way but we will not be involved in disputes between you and your insurance carrier. This includes but is not limited to: deductibles, co-pays, non-covered charges and “usual and customary” charges. You are ultimately responsible for the timely payment of your account.

**Copayments** are due at check in.

**Payment Arrangements:** Full balance is due at the time of service, however if you are unable to pay the full balance, payment arrangements can be made prior to your visit. We accept cash, checks, and all major credit cards.

**Unpaid balances** are subject to finance charges after 90 days and outstanding balances will be collected at check-in time.

**Self Pay:** We require that you pay one-half of estimated charges before you see the physician and one-half of estimated surgery charges before any surgical procedure is scheduled.
Additional Information and/or Fees:
- $45 charge for insufficient funds check
- $25 for completing disability forms, per request.
- $25 for medical records that are not sent to referring or consulting physicians.
- $3.00 per disk for copies of x-rays.
- Parents or guardians of minors are responsible for full payment and will receive billing statements for the minors. It is preferred that minors be accompanied by a parent or guardian but in the event that is not possible, unaccompanied minors will not be treated without a signed release from a parent or guardian.

I have read and agree to the financial policy of Dr. Hoffman & Associates, P.A.

__________________________  __________________________
Patient Name (please print)    Patient/Responsible Party Signature     Date
New Patient Info

Scott J. Hoffman, D.P.M.
1205 Ryan’s Road
Worthington, MN 56187-0848

Appointments

Appointment Date ________________
Time ________________

Chart ____________________________

Account ____________________________________

Patient Information

Patient Name (please print) __________________________
Maiden __________________________________________
First ___________________________ Middle Init. ______
Last _________________________________________
Address _________________________________________
City ________________________ St ______ Zip ______
Social Sec. # ____________________________
Cell Phone __________________________
Home Phone _________________________
Date of Birth __________ Gender _____ Age _____
E-mail _____________________________
Employer __________________________
Address ______________________________________
City ______ St ______ Zip ______
Work Phone _________________________

Parent or Guardian Name if Under 18 years of age:

Name ___________________ Relationship to Patient ______
Address _________________________________________
City ________________________ St ______ Zip ______

Emergency Contacts

Name of Person (& relationship to patient) to contact in case of emergency:

Work Phone ____________________________________
Hm/Cell Phone ____________________/ ____________________
Address _________________________________________
City ________________________ St ______ Zip ______

Complete if Married (patient)

Name of Spouse ___________________ DOB ____________________
Work/Cell Phone ____________________/ ____________________
Employer __________________________
Address _________________________________________
City ________________________ St ______ Zip ______

Family Doctor __________________________
Referring Physician _________________________

How did you hear about us? ___________________________

Guardian/Legal Representative

If you are not financially responsible for payment for your services, please write the information for the responsible party below.

Name _____________________________
Address ____________________________________
City ________________________ State Zip ______
Email: ____________________________________
Primary Phone: (_______) __________

Are you a student?

☐ No ☐ Full-time Student ☐ Part-time Student

Insurance Assignment & Release

I certify that I am covered by the above listed medical insurance and I agree to assign all benefits, if any, otherwise payable to me directly to the provider of care for services rendered to me. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The doctor may use my health care information and may disclose such information to the above named insurance company(ies) and their agents for the purpose of obtaining verification of insurance eligibility, determining insurance benefits payable for services and for obtaining payment for services provided to me.

I understand that my insurance may only pay a portion of the fee for the services provided. I understand that there may be a co-payment required at the time of my visit and there may be a balance remaining (or co-insurance) for which I am personally responsible for paying. I understand that co-payments are due and must be paid at the time of my visit.

Date ________________________________
Relationship to Patient ____________________________
I understand that I am financially responsible for all charges not covered by insurance. In the event that there is a balance unpaid by insurance, I guarantee the balance be paid:

- Cash
- Check
- CC/Debit Card #_______ ______ ______ ______ exp:___ ___

I understand any balance is considered delinquent after 90 days:

X __________________________________________________

FINANCIAL AGREEMENT:
I understand that I am financially responsible for all charges not covered by insurance. In the event that there is a balance unpaid by insurance, I guarantee the balance be paid:

I understand any balance is considered delinquent after 90 days:

X __________________________________________________

PRE-AUTHORIZATION
Our office will pre-authorize surgeries; however, pre-authorization does not guarantee payment. Questions regarding payment or benefits should be directed to your insurance carrier.

If your insurance company requires that you go to a specific hospital or facility in order to receive benefits for surgery, tests, or therapy, it is your responsibility to let us know.

Guidelines when calling your insurance company:
Is pre-authorization required?
Is a second opinion required?
Are you in a waiting period for pre-existing conditions?

X __________________________________________________ Date _____________
Review of Systems
Check all symptoms/conditions you currently have or have had in the past and explain:

- Thyroid Disease
- Parkinsons
- Infections after Surgery
- Diabetes
- Stroke
- Venereal Disease
- Heart Disease
- Seizure
- Hepatitis
- Heart Murmur
- Nervous Disorder
- (HIV) AIDS
- Valve Problems
- Epilepsy
- Osteomyelitis
- High Blood Pressure
- Headaches
- Kidney Stones
- Chest Pain
- Asthma or Emphysema
- Blood in Urine
- Dizziness
- Pneumonia
- Painful Urination
- Fracture/Broken Bone
- Lung Disease
- Frequent Rashes
- Body Part
- Ulcers
- Skin Irritation
- Joint Pain
- Rectal Bleeding
- Swelling of the Feet
- Body Part
- Change in Bowel Habits
- Paralysis
- Joint Swelling
- Hepatitis (Jaundice or Liver Disease)
- Numbness
- Body Part
- Gallbladder Disease
- Depression
- Back Pain/Injury
- Heartburn
- Anxiety
- High Cholesterol
- Double Vision
- Schizophrenia
- Osteoporosis
- Nosebleeds
- Bipolar Disorder
- Carpal Tunnel
- Difficulty Swallowing
- Drug or Alcohol Abuse
- Rheumatoid Arthritis
- Hoarseness
- Other Please Explain
- Multiple Sclerosis
- Ringing in Ears
- Numbness

Reviewed by Provider: ___________________________ Date: ___________________________
# Medical History

**Surgeries/Hospitalizations/Illness**

<table>
<thead>
<tr>
<th>Surgeries/Hospitalizations/Illness</th>
<th>Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
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<td>2.</td>
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<td>9.</td>
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<td>10.</td>
<td></td>
</tr>
</tbody>
</table>

- Have you ever had general anesthesia? [ ] Yes [ ] No
- Have any problems with anesthesia? [ ] Yes [ ] No
  - Describe: __________________________________________
- Have you ever had a blood transfusion? [ ] Yes [ ] No
- Date of last tetanus booster: ________________
- Are you pregnant? [ ] Yes [ ] No

## Family History (please circle sister or brother)

<table>
<thead>
<tr>
<th>Member</th>
<th>Age</th>
<th>Living/Deceased</th>
<th>Health Status or Cause of Death</th>
</tr>
</thead>
<tbody>
<tr>
<td>Father</td>
<td></td>
<td>L D</td>
<td>Heart Disease Stroke Diabetes Cancer (location _____________) High Blood Pressure Thyroid Disease Other Other</td>
</tr>
<tr>
<td>Mother</td>
<td></td>
<td>L D</td>
<td>Heart Disease Stroke Diabetes Cancer (location _____________) High Blood Pressure Thyroid Disease Other Other</td>
</tr>
<tr>
<td>Sister or Brother</td>
<td></td>
<td>L D</td>
<td>Heart Disease Stroke Diabetes Cancer (location _____________) High Blood Pressure Thyroid Disease Other Other</td>
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<td></td>
<td>L D</td>
<td>Heart Disease Stroke Diabetes Cancer (location _____________) High Blood Pressure Thyroid Disease Other Other</td>
</tr>
</tbody>
</table>

## Social History

- Occupation ____________________________ Employer ____________________________ Length of Employment ______
- Marital status ____________________________
- Exercise (type/frequency) ____________________________ Special Diet (describe) ____________________________
- History of illegal drug abuse? [ ] No [ ] Yes Describe: ____________________________
- Do you smoke? [ ] No [ ] Yes ______ packs per day for _______ years Year you quit smoking ________
- Alcohol use [ ] No [ ] Yes 1-2 drinks per week 3-5 drinks per week 1-3 drinks per month Other ____________________________

Reviewed by Provider: ____________________________ Date: ____________________________
Allergies

Please tell us of any allergies you have and potential reactions (i.e. nausea, hives) when encountered:

- Aspirin: ______________________
- Codeine: ______________________
- Demerol: ______________________
- Iodine: ______________________
- Novocain: ______________________
- Penicillin: ______________________
- Sulfa: ______________________
- Other: ______________________

Are you now or have you been under another doctor’s care for any reason in the last two years?

- Yes
- No

If yes, for what reason? ______________________

What is your shoe size? ______________________

What is your last known weight? ______________________

What is your last known blood pressure? ______

Treatment Consent

I hereby consent and give my permission to the doctor (and the doctor’s assistants or designated replacement) to administer and perform such procedures upon me as the doctor deems necessary.

Signature of patient, guarantor or responsible party

Print name of person whose signature appears

Date

Relationship to patient

I certify the above information is correct to the best of my knowledge. I will not hold my doctor or any members of his/her staff responsible for any errors or omissions I may have made in the completion of this form.

Patient Signatures: ______________________

Date: ______________________

Reviewed by Provider: ______________________

Date: ______________________