Patient Information

Patient ID # _____

☐ SINGLE ☐ MARRIED ☐ CHILD ☐ OTHER DATE OF BIRTH: _____/_____/_____
Month Day Year

NAME: _____ SOCIAL SECURITY #: _____
First Middle Initial Last

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

EMERGENCY CONTACT: _____ PHONE: (___) _____

HOME PHONE: (___) _____ CELL: (___) _____ EMAIL: _____

EMPLOYER: _____ OCCUPATION: _____ PHONE: (___) _____

MAIN COMPLAINT: _____

PREVIOUS PODIATRIST: _____

PRIMARY INSURANCE: _____SECONDARY/SUPPLEMENTAL_____

I.D. NUMBER: _____ GROUP NUMBER: _____

IF SUBSCRIBER IS OTHER THAN PATIENT, PLEASE HAVE THE SUBSCRIBER COMPLETE THE FOLLOWING:

NAME: _____ ADDRESS: _____ PHONE: _____

EMPLOYER: _____ ADDRESS: _____ PHONE: _____

SUBSCRIBER'S SOCIAL SECURITY NO.: _____ SUBSCRIBER'S DOB: _____

SUBSCRIBER'S RELATIONSHIP TO PATIENT: _____-_____

I HEREBY GIVE YOU PERMISSION TO TREAT MY FEET, MEDICALLY, SURGICALLY OR ANY MEASURES OTHERWISE DEEMED APPROPRIATE.

I ALSO AUTHORIZE ANY EMPLOYEE OF ABOUT FEET PODIATRY CENTER OR AFP SURGERY CENTER TO LEAVE A MESSAGE ON VOICE MAIL, IF I AM NOT AVAILABLE, REGARDING ANY APPOINT - MENTS, REMINDER CALLS, TEST RESULTS &/OR OTHER ANY MATTERS CONCERNING MY CARE. IF YOU WOULD LIKE TO DECLINE THIS OPTION, PLEASE PLACE YOUR INITIALS HERE:_____.

I UNDERSTAND X-RAYS OR ANY TYPE OF TREATMENT THAT IS PERFORMED AT ABOUT FEET PODIATRY CENTER OR AFP SURGERY CENTER WILL BE AT MY EXPENSE OR THE EXPENSE OF MY INSURANCE COMPANY, IF APPLICABLE. ALL CO-PAYS AND DEDUCTIBLES ARE THE PATIENTS' RESPONSIBILITY AND WILL BE EXPECTED TO BE PAID IN FULL AT TIME OF SERVICE. OTHER ARRANGEMENTS MAY BE MADE UNDER SPECIAL CIRCUMSTANCES AT AN ADDITIONAL COST.

PAYMENT FOR SERVICES PERFORMED

OUR OFFICE ACCEPTS DISCOVER, MASTERCARD AND VISA FOR YOUR CONVENIENCE, AS WELL AS CASH OR CHECK. PLEASE NOTE THAT ANY CHECK THAT IS RETURNED TO OUR OFFICE FOR ANY REASON, THERE WILL BE A $25 SERVICE CHARGE. ALL PAYMENTS ARE EXPECTED AT THE TIME OF SERVICE AND ALL OUTSTANDING BALANCES ARE DUE WITHIN 30 DAYS, UNLESS PRIOR ARRANGEMENTS HAVE BEEN MADE WITH THE BILLING DEPARTMENT. ALL PAST DUE ACCOUNTS WILL BE ASSESSED AT 1-1/2% PER MONTH FINANCE CHARGE AFTER 60 DAYS. ALL BALANCES THAT REACH 90 DAYS PAST DUE WILL BE SENT TO A COLLECTION AGENCY.

FOR CLAIMS PURPOSES, I HEREBY AUTHORIZE ABOUT FEET PODIATRY CENTER & AFP SURGERY CENTER TO RELEASE INFORMATION ABOUT ME (NOT LIMITED TO, BUT INCLUDING, MEDICAL HISTORY, DIAGNOSIS AND TREATMENT) TO ANY PERSON(S) PERFORMING BUSINESS OR LEGAL SERVICES ON THEIR BEHALF IN CONNECTION WITH: a) MY CLAIM(S) FOR MEDICAL BENEFITS; b) DISABILITY COVERAGE; OR c) AS REQUIRED BY LAW. I ALSO AUTHORIZE ALL INSURANCE PAYMENTS BE PAID TO THE PHYSICIAN AND THAT COPIES OF INSURANCE FORMS ARE TO BE TREATED AS ORIGINALS.

DISCLOSURE: AFP SURGERY CENTER IS A PHYSICIAN OWNED FACILITY (JASON S. HEARN, DPM) IN THE SAME LOCATION AS YOUR PHYSICAN'S OFFICE AT 142 JOHN ROBERT THOMAS DRIVE, EXTON, PA. AFP SURGERY CENTER IS A PHYSICIAN OWNED FACILITY AND THE PHYSICIANS HAVE A FINANCIAL INTEREST IN THIS CENTER. YOU ARE FREE TO HAVE YOUR PROCEDURE DONE AT AN ALTERNATIVE FACILITY. IF THAT IS YOUR PREFERENCE, PLEASE BE REASUURED THAT WILL NOT AFFECT YOUR RELATIONSHIP WITH YOUR PHYSICIAN.

_____

SIGNATURE **DATE**

*updated 10/1/25

Medical History

Patient Name: _____ Date of Birth: _____

Family Physician: _____ Phone Number: _____

Pharmacy Name: _____Phone Number: _____

Height: _____ Weight: _____ Age: _____ Shoe size: _____

Personal Medical History Have you ever had any of the following?

- ☐ No Significant Health Problems

HEART/LUNGS
- ☐ Asthma
- ☐ Heart Disease
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Heart Murmur
- ☐ Pneumonia
- ☐ Other _____

ENDOCRINE
- ☐ Adrenal Disorder
- ☐ Diabetes
- ☐ Polycystic Ovary Syndrome
- ☐ Hypothyroidism
- ☐ Hyperthyroidism
- ☐ Other_____

KIDNEY/BLADDER
- ☐ Chronic Kidney Bladder Disease
- ☐ Kidney Stones
- ☐ Overactive Bladder
- ☐ Renal Failure
- ☐ Urinary Incontinence
- ☐ Other _____

ORTHOPEDIC
- ☐ Arthritis
- ☐ Fractures/Broken Bones
- ☐ Other_____

SKIN
- ☐ Eczema
- ☐ Psoriasis

STOMACH/BOWEL
- ☐ Celiac Disease
- ☐ Stomach Ulcers
- ☐ Ulcerative Colitis
- ☐ Crohn's Disease
- ☐ Other Liver, Stomach and Bowel Disease

NEUROLOGICAL
- ☐ Concussion
- ☐ Seizures
- ☐ Migraines/Severe Headaches
- ☐ Multiple Sclerosis
- ☐ Muscular Dystrophy
- ☐ Stroke/TIA
- ☐ Other

EARS/EYES/NOSE/THROAT
- ☐ Chronic Sinus Infections
- ☐ Eye Disorders
- ☐ Hearing Loss
- ☐ Nasal Allergies
- ☐ Sleep Apnea
- ☐ CPAP Machine
- ☐ Other_____

MENTAL HEALTH
- ☐ ADHD
- ☐ Anxiety Disorder
- ☐ Depression
- ☐ Bipolar Disorder
- ☐ Dementia
- ☐ Parkinson's Disease
- ☐ Alzheimer
- ☐ Other _____

Do you smoke? Yes or No If so how much?_ ----------
Do you drink alcohol? Yes or No If so how much? _____

Are you pregnant? Yes or No If yes, due date: _____

Allergies:

Have you ever had an allergic reaction? Yes or No
Medication Allergies: _____
Food Allergies: _____
Other: _____

Medications

Are you currently taking any medications? Yes or No
(Please include dosage)

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____

Surgical History: _____

Do you have an Advanced Directive? Yes or No → Would you like information regarding this? Yes or No
Would you like a copy of Non Discrimination? Yes or No

Patient received a copy of the Patient Bill of Rights _____ (initials)