33 Gateway Shopping Center
Edwardsville, Pa 18704
Phone: 570-287-1955
Fax: 570-287-1995

NEPA
Foot & Ankle
Specialists
Shelly Levulis, DPM

3579 Memorial Highway
Dallas, Pa 18612
Phone: 570-675-8382
Fax: 570-675-7823

NEW PATIENT INTAKE FORM

LAST NAME: _____ ***M.I.*** _____

FIRST NAME: _____

ADDRESS: _____

_____

CITY: _____ ***STATE:*** _____ ***ZIP:*** _____

HOME PHONE: ( ) _____

CELL PHONE: ( ) _____

BUSINESS PHONE: ( ) _____

EMAIL: _____

BIRTH DATE: _____

SOC SEC# _____

MARITAL STATUS: Single Married Divorced Widowed

EMERGENCY CONTACT NAME _____

PHONE _____ ***RELATIONSHIP*** _____

Primary Care Physician _____

Phone: _____ ***Fax:*** _____

Date last seen _____

Pharmacy _____

Reason for Visit:

_____

_____

FOOT: Right - Left - Both

Pain (less) 0 1 2 3 4 5 6 7 8 9 10 (more) Please circle one

Shoe Size: _____

PLEASE TELL US WHO REFERRED YOU TO OUR OFFICE:

_____

INSURANCE INFORMATION

Who is your Insurance carrier?_____

Are you the policy holder? Yes No

If you are NOT the policy holder, what is your relationship to the policy holder?_____

Spouse Dependent child Dependent child over 18 and a full time student

Policy holders name (IF NOT YOU) _____

Policy holders SS# _____ Date of Birth:_____

READ AND SIGN BELOW

I hereby give permission for SHELLY LEVULIS, DPM to share my medical records with my insurance carrier upon their written request for the benefit of supporting my medical treatment at this office. I also do hereby give permission for SHELLY LEVULIS, DPM to bill my insurance carrier for the purposes of obtaining payment for services rendered here at this office.

Print your name_____Date_____

Sign your name_____Date_____

ACKNOWLEDMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that a copy of the Notice of Privacy Practices is available to me upon request. I have read, or have had the opportunity to read them if I so choose and understood the Notice.

Print your name_____

Sign your name_____

May we leave a message with anyone other than yourself: □ yes □ no

If yes, with whom may we leave the message: □ spouse □ other

□ anyone answering the phone

PAST MEDICAL HISTORY

Height: _____ ***Weight:*** _____

Current Medicine Used

Drug Name	*Dosage*

Are you up to date on all immunizations: ❑ **YES** ❑ **NO** ❑ **UNKNOWN**

ALLERGIES: _____

_____

SURGERIES: _____

_____

Do you now or have you ever had: *(check if "yes")*

❑ Cancer	❑ Heart problems	❑ Asthma	❑ High Cholesterol
❑ COPD	❑ Leukemia	❑ Stroke	❑ Hypothyroidism
❑ Cataracts	❑ Diabetes	❑ Epilepsy	❑ Hyperthyroidism
❑ Nervous breakdown	❑ Stomach ulcers	❑ Rheumatic fever	❑ Gout
❑ Bad headaches	❑ Jaundice	❑ Colitis	
❑ Kidney disease	❑ Pneumonia	❑ Psoriasis	
❑ Anemia	❑ HIV/AIDS	❑ High Blood Pressure	
❑ Emphysema	❑ Glaucoma	❑ Tuberculosis	

Other significant illness: (please list)_____

_____

_____

_____

_____

TOBACCO, ALCOHOL, RECREATIONAL DRUG USE

Do you use tobacco in any way? ❑ **NO** ❑ **YES**
If yes, frequency? _____
If yes, are you interested in quitting? ❑ **NO** ❑ **YES**

Have you smoked in the past? ❑ **NO** ❑ **YES**
If yes, when did you stop? _____

Do you drink alcoholic beverages? ❑ **NO** ❑ **YES**
If yes, frequency? (Drinks per week) _____

Do you use recreational drugs? ❑ **NO** ❑ **YES**
If yes, type? _____
If yes, are you interested in quitting? ❑ **NO** ❑ **YES**

REVIEW OF SYSTEMS

Please check any **CURRENT** symptoms you may have

Constitutional
- ❑ Recent Fever Or Sweats
- ❑ Unexplained Weight Loss/Gain
- ❑ Unexplained Weakness/Fatigue
- ❑ Decline In Libido

Respiratory
- ❑ Cough/Wheeze
- ❑ Coughing Up Blood

Skin
- ❑ Rash
- ❑ New Or Change In Mole
- ❑ Thin, Ridged, Or Splitting, Crumbling Nails

Eyes
- ❑ Changes In Vision

Gastrointestinal
- ❑ Heartburn/Reflux
- ❑ Blood Or Change In Bowel Movement
- ❑ Nausea/Vomiting/Diarrhea
- ❑ Pain In Abdomen
- ❑ Irritable Bowel Syndrome/Digestion Problems
- ❑ Fainting
- ❑ Painful/Bloody Urination
- ❑ Leaking Urine
- ❑ Nighttime Urination
- ❑ Unusual Vaginal Bleeding
- ❑ Concern With Sexual Function

Blood/Lymphatic
- ❑ Unexplained Lumps
- ❑ Easy Bruising/Bleeding

Neurological
- ❑ Headaches
- ❑ Memory Loss

Ears/Nose/Throat/Mouth
- ❑ Difficultly Hearing
- ❑ Hay Fever/Allergies
- ❑ Trouble Swallowing

Cardiovascular
- ❑ Chest Pains/Discomfort
- ❑ Palpitations
- ❑ Short Of Breathe With Exertion

Genitourinary
- ❑ Painful/Bloody Urination

Psychiatric
- ❑ Anxiety/Stress
- ❑ Sleep Problem
- ❑ Depression

Breast
- ❑ Unexplained Lumps
- ❑ Nipple Discharge

Endocrine
- ❑ Cold/Heat Intolerance
- ❑ Increased Thirst/Appetite

Musculoskeletal
- ❑ Muscle/Joint Pain
- ❑ Recent Back Pain

Cancellation/Missed Appointment Policy

Our goal is to provide quality medical care in a timely manner. In order to do so, we have had to implement an appointment/cancellation policy. This policy enables us to better utilize available appointments for our patients in need of medical care.

Cancellation of an Appointment
In order to be respectful of the medical needs of other patients, please be courteous and call if you are unable to attend an appointment. This time will be reallocated to someone who is in urgent need of treatment. If it is necessary to cancel your scheduled appointment, we require that you call at least 24 hours in advance. Appointments are in high demand, and your early cancellation will give another person the possibility to have access to timely medical care.

Late Cancellations:
Late Cancellations will be considered as a "no-show".

No-Show Policy
A "no-show" is someone who misses an appointment without cancelling it in an adequate manner. "No-shows" inconvenience those individuals who need access to medical care in a timely manner. A failure to present at the time of a scheduled appointment will be recorded in the patient's chart as a "no-show". The first time there is a "no-show", there will be no charge to the patient. Any additional "no-shows" will result in a fee of $25.00 directly billed to the patient's/responsible parties account, not your insurance company. Three (3) missed appointments, whether consecutive or not , can result in discharging you from the practice.

I have read and understood the Cancellation/Missed Appointment Policy of N.E.P.A. Foot & Ankle Specialist – Shelly Levulis, DPM

_____ _____ Date:___/___/____
Print Name Patient/Responsible Party Signature