PATIENT INFORMATION

Patient's Full Name: _____
(First) (Middle) (Last)

Birth Date: _____ Age: _____ Race/Ethnicity: _____ Sex: ☐ Male ☐ Female

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed SS #: _____

Address: _____ City: _____

State: _____ ZIP: _____ Email: _____

Mobile #: _____ Work #: _____ Home #: _____

Patient Employed By: _____

How Long: _____ Employer's Address: _____

IF APPLICABLE

Spouse's Name: _____ SS #: _____

Birth Date: _____ Mobile #: _____

Spouse Employed By: _____ Occupation: _____

How Long: _____ Employer's Address: _____

PLEASE FILL OUT IF PATIENT IS UNDER PARENTS' INSURANCE PLAN(S)

Father's Mobile #: _____ Mother's Mobile #: _____

Father Employed By: _____ SS #: _____

Occupation: _____ How Long: _____ Employer's Phone #: _____

Employer's Address: _____

Mother Employed By: _____ SS #: _____

Occupation: _____ How Long: _____ Employer's Phone #: _____

Employer's Address: _____

Name of Primary Insurance Company: _____

Primary Policyholder's Name: _____

SS #: _____ Birth Date: _____ Phone #: _____

Employer: _____ ID #: _____ Group #: _____

Name of Secondary Insurance Company: _____

Primary Policyholder's Name: _____

SS #: _____ Birth Date: _____ Phone #: _____

Employer: _____ ID #: _____ Group #: _____

Patient's Name: _____ **Date of Birth:** _____

REASON FOR VISIT

Please describe your present foot or ankle concerns, problems or symptoms:

1. _____
2. _____

Have you ever been seen by a podiatrist? ☐ Yes ☐ No

If yes, for what reason? (Please include who and when.) _____

_____

How did you hear about FAAWC? _____

MEDICAL HISTORY

When was your last physical exam? _____

Family doctor's first and last names: _____ Phone #: (____) _____

1. Are you currently under medical treatment? ☐ Yes ☐ No

If yes, for what? _____

2. Please check any of the following to which you've had allergic reactions: ☐ **NONE**

☐ Adhesive Tape ☐ Iodine ☐ Penicillin

☐ Aspirin ☐ Latex ☐ Sulfa

☐ Codeine ☐ Local Anesthetics (Novocaine)

☐ Other (please explain): _____

3. Are you currently taking any prescription or over-the-counter medications? ☐ Yes ☐ No

☐ Please check this box if you have brought an updated list of your medications with you.

If you answered "yes" and you didn't bring an updated list, please list them:

Name of Medication/Dosage/When Taken	**Reason for Medication**

4. Primary pharmacy, location and phone #:

_____

Patient's Name: _____ **Date of Birth:** _____

MEDICAL HISTORY (CONTINUED)

5. Have *YOU* ever had the following? (Please check all that apply.)

- ☐ Acid Reflux
- ☐ Anemia (Low Blood Count)
- ☐ Arthritis Type: _____
- ☐ Asthma
- ☐ Blindness
- ☐ Blood Clots (e.g. DVT)
- ☐ Cancer Type: _____
- ☐ Chemotherapy
- ☐ Chronic Fatigue Syndrome
- ☐ COPD (Emphysema)
- ☐ Diabetes How Long: _____
- ☐ Eczema
- ☐ Epilepsy
- ☐ Fibromyalgia
- ☐ Glaucoma
- ☐ Gout
- ☐ Hard of Hearing
- ☐ Hardening of Arteries
- ☐ Heart Disease
- ☐ Heart Murmur (e.g. AFib, VFib)
- ☐ Hepatitis A B C D (circle one)
- ☐ Herniated Disc (What level? _____)
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ HIV/AIDS
- ☐ Hypoglycemia (Low Blood Sugar)
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Lupus
- ☐ Migraine Headaches
- ☐ Mitral Valve Prolapse
- ☐ Multiple Sclerosis
- ☐ Muscular Dystrophy
- ☐ Osteoarthritis
- ☐ Peripheral Arterial Disease
- ☐ Phlebitis
- ☐ Polio
- ☐ Psoriasis
- ☐ Pulmonary Embolism
- ☐ Rheumatic Fever
- ☐ Rheumatoid Arthritis
- ☐ Sleep Apnea
- ☐ Spinal Stenosis
- ☐ Stomach Ulcer
- ☐ Stroke
- ☐ Thyroid Function ☐ High ☐ Low
- ☐ Tuberculosis ☐ Active ☐ Inactive
- ☐ Varicose Veins
- ☐ Other (please explain): _____

6. Have *YOU* ever had an operation, especially to the legs, ankles or feet? ☐ Yes ☐ No

If yes, please describe: _____

- ☐ Appendix
- ☐ Bypass Surgery ☐ Heart ☐ Leg
- ☐ Catheterization (Heart)
- ☐ Foot/Ankle Surgery
- ☐ Gall Bladder
- ☐ Gastric Bypass or Lap Band (circle one)
- ☐ Hysterectomy
- ☐ Joint Replacement (Which? _____)
- ☐ Orthopedic (Body area? _____)
- ☐ Pacemaker/Defibrillator (circle one)
- ☐ Stents ☐ Heart ☐ Leg
- ☐ Tonsils

Patient's Name: _____ **Date of Birth:** _____

MEDICAL HISTORY (CONTINUED)

7. Has *any member of your immediate family* been treated for the following? ☐ **UNKNOWN**
(Please check all that apply AND circle the appropriate family member.)
F = father M = mother B = brother Si = sister So = son D = daughter

☐ Arthritis	F	M	B	Si	So	D	☐ Heart Disease	F	M	B	Si	So	D
☐ Cancer	F	M	B	Si	So	D	☐ High Blood Pressure	F	M	B	Si	So	D
☐ Diabetes	F	M	B	Si	So	D							

8. Do you smoke? ☐ Currently ☐ Formerly ☐ Never

9. Do you use illegal drugs? ☐ Yes ☐ No

10. Do you use alcohol? ☐ Yes ☐ No

11. What is your marital status? ☐ Single ☐ Married ☐ Divorced ☐ Widowed

12. What is your occupation? _____ ☐ Retired

13. Do you have or are you subject to any of the following? (Please check all that apply.)

☐ Back Pain	☐ Fever/Chills
☐ Balance Problems	☐ Foot/Leg Pain at Night
☐ Bleeding/Clotting Disorder	☐ Foot/Leg Cramps When Walking
☐ Bleeding Tendency	☐ Foot/Leg Cramps at Night
☐ Burning Pain/Tingling/Numbness	☐ MRSA or VRE Infection (Previous)
☐ Calf Pain	☐ Nausea/Vomiting
☐ Chest Pain	☐ Nervousness
☐ Chronic Infections	☐ Prolonged Bleeding
☐ Circulatory Problems	☐ Shortness of Breath at Rest
☐ Cold Feet	☐ Shortness of Breath When Active
☐ Fainting	☐ Swelling of Legs

☐ **NONE**

I CERTIFY THE INFORMATION ABOVE IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE.

Signature: _____ Date: _____

Patient's Name: _____ **Date of Birth:** _____

PERSONAL INFORMATION

By What Name Do You Want to Be Addressed? _____ **Email:** _____

Primary Care Physician (i.e. Family Doctor): _____

How Did You Hear About Us?

☐ Primary Care Physician ☐ Family Name: _____

☐ Insurance Company ☐ Friend Name: _____

☐ Internet ☐ Patient Name: _____

☐ Other Physician Name: _____

☐ Other: _____

CONSENT FOR RELEASE OF INFORMATION

Please check ALL methods you do <u>NOT</u> want us to use to contact you for each reason:

	Appointment information	Medical information	FAAWC updates (newsletter, etc.)
1. HOME Phone	☐	☐	☐
2. MOBILE Phone	☐	☐	☐
3. MOBILE Text	☐	☐	☐
4. WORK Phone	☐	☐	☐
5. Email	☐	☐	☐
6. Mail	☐	☐	☐

Please list individuals with whom we <u>DO</u> have permission to speak or leave a message:

The FIRST person you list will be considered your primary emergency contact.

Name	**Relationship**	**Phone #**
_____	_____	(____) _____
_____	_____	(____) _____
_____	_____	(____) _____

PATIENT ACKNOWLEDGEMENT FORM NOTICE OF PRIVACY PRACTICES

I have been offered a copy of Notice of Privacy Practices for FAAWC.

☐ Declined ☐ Accepted

Patient Signature: _____ Date Signed: _____

Patient's Name: _____ Date of Birth: _____

ASSIGNMENT OF BENEFITS

I authorize the release of any medical or other associated information to my insurance company or companies necessary to process my medical claims. I also authorize payment of medical benefits directly to Foot & Ankle Wellness Center for medical services and supplies provided.

Signature of Patient (or Parent/Guardian): _____ Date: _____

FINANCIAL POLICY

Full payment is expected on the day medical services are provided unless you have health insurance that we are in contract with. Our contract with your insurance company requires you to pay the following:

CO-PAY:	An amount you must pay at each visit to a doctor.
NON-COVERED SERVICES:	Services that are not covered under your insurance benefit plan.
DEDUCTIBLE:	An amount you must pay first out of your own pocket each year before your insurance will pay for any services.
CO-INSURANCE:	An amount (usually a percentage) of the fee that your insurance company expects you to pay.

We will scan the front and back of your insurance card at your initial visit. After that, you must inform us of any change in coverage and provide us with your new insurance card or you will be responsible for payment of those charges. Some insurance plans require a referral from your primary care physician. You are responsible for obtaining this referral prior to your visit or full payment will be expected for the medical services rendered. If you have two health insurance plans, it is your responsibility to inform us which plan is your PRIMARY coverage that we will bill first and which plan is your SECONDARY coverage. You are expected to inform us if one (or both) insurance plans change or are no longer effective.

We will bill your insurance company on your behalf. If your insurance company does not pay us within 3 months, you may be asked to contact them. It is ultimately your responsibility to convince your insurance company to pay for covered services on your behalf. Any "allowed amount" not paid by your insurance company will be billed to you. You will receive a statement by mail, and you must pay the balance within 30 days. You may use CASH, CHECK or CREDIT CARD. You will be assessed a finance charge monthly (12% annually) or a $1 minimum monthly fee on any unpaid balance.

CANCELLATION POLICY: If you need to cancel or reschedule an appointment, please notify us at least 2 business days in advance to allow us to offer that appointment time to another patient. If you should cancel, reschedule or fail to attend an appointment without 2 business days' notice, a **fee of $35** will be charged.

Person Responsible for Your Bill: _____ Relationship: _____

Billing Address: _____
(Street) (City) (State) (ZIP)

☐ Check if billing address is the same as patient address.

I have read this financial policy and understand it fully.

_____ _____
Signature of Patient (or Parent/Guardian) Date

A copy of this agreement will be provided upon your request.