PATIENT INFORMATION

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

By what name do you want to be addressed? _______________ Birth Date: __________ Age: _____

SS#: ____________________ Race: _______________ Ethnicity: _________ Sex: ☐ Male ☐Female

Language: _____________ Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Mobile #: ___________________ Work #: ____________________ Home (if any) #: _______________

Address: ____ City: ________________________

State: _____________________ ZIP: ___________ Email: ______________________

Employer: ________________________ Occupation: __________________ How Long: ____________

Employer's Address: ____

INSURANCE INFORMATION

Name of Primary Insurance Company: ____

Policyholder's Information

Name: ____ Relationship to Patient: __________

SS #: ______________________ Birth Date: __________________ Phone #: ____________________

ID #: _______________________ Group #: _______________

Employer: ________________________ Occupation: __________________ How Long: ____________

Employer's Address: ____

Name of Secondary Insurance Company: ____

Policyholder's Information

Name: ____ Relationship to Patient: __________

SS #: ______________________ Birth Date: __________________ Phone #: ____________________

Employer: ________________________ ID #: _______________________ Group #: _______________

Occupation: __________________ How Long: ____________

Employer's Address: ____

Patient's Name: ______________________________________ **Date of Birth:** ______________________

PERSONAL INFORMATION

How did you hear about us?

☐ Primary Care Physician

☐ Insurance Company

☐ Internet

☐ Family Name: ________________________________

☐ Friend Name: ________________________________

☐ Patient Name: ________________________________

☐ Other Physician Name: ________________________________

☐ Other: ____

CONSENT FOR RELEASE OF INFORMATION

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

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

Name	Relationship	Phone #
____________________	____________________	(____) ______________
____________________	____________________	(____) ______________
____________________	____________________	(____) ______________

Checkmark below if we SHOULD NOT use a method to contact you:

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

PATIENT ACKNOWLEDGEMENT 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 your insurance card(s) at your initial visit. After that, you must inform us of any change in coverage and provide us with your new insurance card(s). If you do not provide us with your insurance information you will be required to make a full payment at the visit for services rendered. Some insurance plans require a referral from your primary care physician. You are responsible for obtaining this referral prior to your visit or you will be required to make a full payment at your visit for 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.

It is your responsibility to know your insurance benefits. We will bill your insurance company on your behalf. It is ultimately your responsibility to convince your insurance company to pay for covered services on your behalf. Any "allowed amount" not paid or written off by your insurance company will be billed to you. Orthotics and other services not covered by insurance 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.

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

Person Responsible for Your Bill: ____________________________________ Relationship: ____________

Billing Address: ____

(Street) (City) (State) (ZIP)

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.

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.) ____

____

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. Care Team: List other specialists you see such as cardiologists, dermatologists, chiropractors, etc.

Type of Specialist	Name and contact info

3. 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): ____

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

☐ I have brought an updated list of medications with me.

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

Name of Medication/Dosage/When Taken	Reason for Medication

5. Local pharmacy, location and phone #: ____

Mail order pharmacy: ____

Patient's Name: ______________________________ Date of Birth: ______________

MEDICAL HISTORY (CONTINUED)

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

- ☐ Acid Reflux
- ☐ Anemia (Low Blood Count)
- ☐ Anxiety
- ☐ Arthritis Type: ______________
- ☐ Asthma
- ☐ Blindness
- ☐ Blood Clots (e.g. DVT)
- ☐ Cancer Type: ______________
- ☐ Chemotherapy
- ☐ Chronic Fatigue Syndrome
- ☐ COPD (Emphysema)
- ☐ Depression
- ☐ Diabetes ☐Type 1 ☐ Type 2
  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): ____

7. **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)

8. **Has *any member of your immediate family* been treated for the following?** ☐ **UNKNOWN**
   (Please check all that apply AND circle the appropriate family member.) ☐ **NONE**
   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							

9. **Do you smoke or use tobacco products?** ☐ Currently: how much:________ ☐ Formerly ☐ Never
10. **Do you vape?** ☐ Yes ☐ No
11. **Do you use illegal drugs?** ☐ Yes ☐ No
12. **Do you use alcohol?** ☐ Yes ☐ No
13. **What is your marital status?** ☐ Single ☐ Married ☐ Divorced ☐ Widowed
14. **What is your occupation?** ____ ☐ Retired
15. **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: ___________________