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 ☐ Family Name: _____

☐ Insurance Company ☐ Friend Name: _____

☐ Internet ☐ Patient Name: _____

☐ Other Physician Name: _____

☐ Other: _____

CONSENT FOR RELEASE OF INFORMATION

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 #**
_____	_____	(____) _____
_____	_____	(____) _____
_____	_____	(____) _____

Checkmark below if we <u>SHOULD NOT</u> 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 foot and ankle doctor? ☐ 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, endocrinologist, 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 and Dosage **(e.g. Lisinopril 10 mg)**	**Reason for Medication** **(e.g. Diabetes)**
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

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 in Leg (i.e. DVT)
- ☐ Blood Clots in Lung (i.e. Pulmonary Embolism)
- ☐ 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 (i.e. Hypertension)
- ☐ High Cholesterol (i.e. Hyperlipidemia)
- ☐ HIV/AIDS
- ☐ Low Blood Sugar (i.e. Hypoglycemia)
- ☐ 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
- ☐ Vitamin D Deficiency
- ☐ Other (please explain): _____

☐ **NONE**

7. Have *YOU* ever had surgery? ☐ Yes ☐ No

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

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

10. What is your occupation? _____ ☐ Retired

11. Do you smoke or use tobacco products? ☐ Formerly ☐ Never ☐ Yes: How much per day: _____

12. Do you vape? ☐ Yes ☐ No

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

14. How many alcoholic drinks do you consume per week? _____ drinks per week

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

☐ Fever/Chills	☐ Back Pain
☐ Chest Pain	☐ Balance Problems
☐ Cold Feet	☐ Foot/Leg Cramps
☐ Foot/Leg Pain that Wakes You Up at Night	☐ MRSA or VRE Infection (previous)
☐ Swelling of Legs	☐ Burning Pain/Tingling/Numbness
☐ Varicose Veins	☐ Fainting
☐ Shortness of Breath at Rest	☐ Bleeding/Clotting Disorder
☐ Shortness of Breath When Active	☐ Bleeding Tendency
☐ Nausea/Vomiting	☐ Prolonged Bleeding

☐ **NONE**

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

Signature: _____ Date: _____

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

FALL RISK SELF-ASSESSMENT

Please read each statement below. Mark "Yes" if it describes you or "No" if it does not.

1.	**I have fallen in the past year.**	☐ Yes	☐ No
	If yes, were you injured? (Were you treated, even by yourself?)	☐ Yes	☐ No
2.	**I have fallen 3 or more times in the past year.**	☐ Yes	☐ No
3.	**Sometimes I feel unsteady when I am walking.**	☐ Yes	☐ No
4.	**I steady myself by holding onto furniture at home.**	☐ Yes	☐ No
5.	**I am worried about falling.**	☐ Yes	☐ No
6.	**I need to push with my hands to stand up from a chair.**	☐ Yes	☐ No
7.	**I have some trouble stepping up onto a curb.**	☐ Yes	☐ No
8.	**I have decreased or no feeling in my feet (neuropathy).**	☐ Yes	☐ No
9.	**I take medicine that sometimes makes me feel light-headed or more tired than usual.**	☐ Yes	☐ No
10.	**I take medicine to help me sleep or improve my mood.**	☐ Yes	☐ No
11.	**Have you ever had a DXA test (dual-energy X-ray absorptiometry) to check for osteoporosis/low bone density?**	☐ Yes	☐ No

If yes, when? _____