## 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 #: _____

ID #: _____ Group #: _____ Employer: _____

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 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 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: _____