Patient Information

(Please use only black ink)

Name:_____
Last First MI

Address: _____
City State Zip

Birth Date: ____/____/____ **Age:** _____ **SSN:**_____-_____-_____ **Gender:** □M □F

Marital Status: □Single □Married □Divorced □Widow **Spouse/Partner's Name:** _____

Phone (mark preferred number)**: Home:** _____ □**Cell:** _____ **Work:** _____

Ok to leave message with: □ Patient □ Answering Machine □ Spouse □ Anyone answering phone

E-Mail Address: _____

Employer: _____ **Occupation:** _____

Address: _____
City State Zip

Emergency Contact: _____
Name Relation Phone

Primary Doctor: _____
Name City Phone

Primary Language: _____ **Race:** _____**Ethnicity:** _____

If patient is a minor, please complete this section

Parent/Guarantor Name: _____
Last First MI

Address: _____
City State Zip

DOB:___/___/___ **SSN:** _____-____-_____ **Cell:**_____ **Home:**_____

Please Read and Sign: I certify that to the best of my knowledge, all of the above information is correct.

SIGNATURE: _____ **DATE:** _____

FOOT & ANKLE MEDICAL CENTER

Insurance Information

PRIMARY Insurance Company	SECONDARY Insurance Company
Insurance Company:_____	**Insurance Company:**_____
ID #: _____	**ID #:** _____
Group#: _____	**Group#:** _____
Policyholder: _____	**Policyholder:** _____
DOB: ____/____/____	**DOB:** ____/____/____
Relationship: Self /□Spouse / Parent/Guardian	**Relationship: Self / □Spouse /□Parent/Guardian**

□

Financial Agreement

We are committed to providing you with the best possible care. In order to achieve that goal, we need your assistance and your understanding of our payment policy.

- This office will file insurance claims for all insurance companies. It is your responsibility to provide current and accurate insurance information at the time of your visit.
- **You remain responsible for the payment of your account**. The filing of insurance claims is a courtesy that we extend to all our patients. However, your insurance policy may not cover all services rendered. Therefore, all charges are your responsibility, not your Insurance Company's responsibility. Please understand that insurance is a contract between you and your insurance company.
- **Patients are responsible for their co-payments, co-insurance, or unmet deductibles at the time of service.** Payment is accepted in the form of cash, check, Visa, Discover, or MasterCard. We also offer financing options through an outside, third party company --- Care Credit.
- Returned checks and balances older than 30 days are subject to collection fees.
- **We request 24 hours notice for appointment cancellations** so we have a chance to fill your appointment slot. **Otherwise a $25.00 "No Show" fee** may be billed to your account.

We encourage you to contact us for assistance in the management of your account. If you have any questions or need to make financial arrangements, please ask. We are here to help.

Signature: _____ Date: _____

Printed Name: _____

Relationship to Patient: _____

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Brief Medical History

Describe your problem: _____

_____

Accident/Injury: □Y □N **Work Related:** □Y □ N **Date of Injury:** / /

MEDICATIONS AND SUPPLEMENTS:

Medication	Dose	Times Per Day	Medication	Dose	Times Per Day

(if more room is needed for medications, please list on the back of this page.)

Pharmacy Name: _____ **Pharmacy Phone:** _____

ALLERGIES or REACTIONS to MEDICINES\FOODS\OTHER AGENTS:

Medication or Allergen	Reaction or Side Effect

PERSONAL MEDICAL HISTORY:

	AIDS/HIV		Epilepsy			Neuropathy
	Anemia		Eye Problems			Phlebitis
	Angina		Foot or leg Cramps			Psychiatric Care
	Arthritis		Gout			Pneumonia
	Asthma		Headaches			Radiation Treatment
	Artificial Heart Valve		Hearing Loss			Rash
	Back Problems		Heart Disease			Respiratory Disease
	Bleeding Disorders		Hepatitis A B C			Special Diet
	Cancer		High Blood Pressure			Stroke
	Chemical Dependency		High Cholesterol			Swelling in Ankles or Feet
	Chest Pain		Hypothyroidism			Tired Feet
	Circulatory Problems		Joint Replacement			Tuberculosis
	Depression		Kidney Problems			Ulcers
	Diabetes Recent A1c:		Liver Disease			Varicose Veins
	Ear Problems		Low Blood Pressure			Venereal Disease

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SURGICAL HISTORY:

Date	Surgery or Reason for Hospitalization	Date	Surgery or Reason for Hospitalization

(if more room is needed, please use the back of this page.)

FAMILY HISTORY:

	Arthritis
	Cancer of :
	Diabetes
	Gout
	Heart Disease
	High Blood Pressure
	Stroke
Other:	

SOCIAL HISTORY: how much/ how often

Activity				Quantity
Cigarettes	**Y**	**N**	**Quit**	
Chewing Tobacco	**Y**	**N**	**Quit**	
Alcohol	**Y**	**N**	**Quit**	
Standing at work				
Recreation:				
Other:				

OTHER:

Please list any other issues the doctor should be aware of.

_____

_____

_____

_____

TREATMENT CONSENT:

I herby consent and give my permission to the doctor (and the doctor's assistants or designated replacement) to administer and perform such procedures upon me as the doctor deems necessary.

Signature:_____ **Date:** _____

Printed Name: _____

Relationship to Patient: _____

Patient Consent Form

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPPAA), I have certain rights regarding my protected health information. I understand that this information can and will be used to:

- Conduct, Plan and direct my treatment and follow-up among multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been informed by you of your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such *Notice of Privacy Practices* prior to signing this consent. I understand that this organization has the right to change its *Notice of Privacy Practice.*

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or health care operations. I also understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Persons Authorized to access my information:

1. _____ Relationship: _____

2. _____ Relationship: _____

3. _____ Relationship: _____

Signature: _____ **Date:** _____

Printed Name: _____

Relationship to the Patient: _____