Family Foot and Ankle Centers, P.C.

Patient Name _____ Birthdate _____ SSN# _____
(First, Middle Initial, Last)

Physical Address _____

Mailing Address (if different than Physical Address) _____

City _____ State _____ Zip Code _____ Gender: Male/Female

Home Phone (_____) _____ Cell Phone (_____) _____ Occupation _____

Email Address: _____

Race: _____ Ethnicity (circle one): ~~Hispanic/Latino~~ ~~Non-Hispanic/Latino~~ ~~Not Specified~~

Are you: Single / Married / Divorced / Separated / Widowed / Partnered / Minor

Spouse's Name _____ Birthdate _____ Spouse's SSN# _____

Emergency Contact (Name/Relationship) _____

(Phone #1) _____ (Phone #2) _____

Patient Employer _____ Employer Phone (_____) _____

Employer Address _____

Whom may we thank for referring you? _____

Family Doctor _____ Last Visit Date _____

Chief complaint for which you came to be treated _____

Have you ever been to a Podiatrist before? _____ if yes, please list _____

Pharmacy Name & City _____ Phone (____) _____

Primary Insurance Name _____

Subscriber _____ Relationship _____ Birthdate _____

Secondary Insurance Name _____

Subscriber _____ Relationship _____ Birthdate _____

Insurance / Medicare / Medigap Assignment and Release

I certify that I have insurance coverage with _____ and assign directly to **Family Foot and Ankle Centers, P.C.** all insurance benefits, if any, otherwise payable to me for services rendered by the provider. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

To the extent permitted by law, I authorize any holder of medical or other information about me to release to the Centers for Medicare and Medicaid Service, my Medigap insurer, and their agents any information needed to determine these benefits for related services.

The above-named doctor my use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____ _____
Signature of Patient, Beneficiary, Guardian or Personal Representative Relationship to Patient

_____ _____
Please print name of Patient, Beneficiary, Guardian or Personal Representative Date

Family History (Please circle)

- Arthritis Mother Father
- Cancer Mother Father
- Diabetes Mother Father
- Foot Problems Mother Father
- Heart Problems Mother Father
- Kidney Problems Mother Father

Allergies (Please circle all that apply) or **No Known Allergies**

- Adhesive/Tape	- Demerol	- Penicillin
- Aspirin	- Hydrocodone	- Seafoods
- Cephalexin (Keflex)	- Iodine	- Sulfa
- Codeine	- Local Anesthetics	- Other _____

Social History (Please answer or circle accordingly)

- Smoker: Never or Former-smoker or # packs per day _____
- Alcohol use: # of drinks per week _____
- Caffeine use (coffee, tea, pop): YES or NO

Medications (Includes prescriptions and over-the-counter medications/vitamins) – **Please list dosage**

_____

_____

_____

Medical History (Please circle all that apply) ** Includes past and present conditions

- Acid Reflux (GERD)
- AIDS/HIV
- Allergies to Anesthetics
- Allergies to Medicine or Drugs
- Anemia
- Angina (chest pain)
- Arthritis
- Artificial Heart Valves/Joints
- Asthma
- Back Problems
- Bleeding Disorders
- **Cancer *****_____
- Chemical Dependency
- Chicken Pox
- Circulatory Problems
- Diabetes Type 1
- Diabetes Type 2

- DVT (blood clot)
- Ear Problems
- Epilepsy
- Eye Problems
- Fainting
- Foot/Leg Cramps
- Gout
- Headaches
- Heart Disease
- Hemophilia
- Hepatitis
- Hernia
- High Blood Pressure
- Jaundice
- Kidney Problems
- Liver Disease
- Low Blood Pressure

- Measles
- Mumps
- Neuropathy
- Phlebitis
- Pregnancy
- Psychiatric Care
- Radiation Treatment
- Rash
- Respiratory Disease
- Rheumatic Fever
- Rheumatoid Arthritis
- Scarlet Fever
- Shingles
- Shortness of Breath
- Sinus Problems
- Special Diet
- Stroke

- Swelling in Ankles/Feet
- Swollen Neck Glands
- Thyroid Problems
- Tired Feet
- Tuberculosis
- Ulcers
- Varicose Veins
- Venereal Disease
- Weight Loss, unexplained

***Please list type of cancer you had/have**

Surgeries & Hospitalizations (Please list **ALL** surgeries throughout lifetime)

_____

_____

Treatment Consent

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

_____ _____

Signature of Patient, Parent, Guardian or Personal Representative Date

_____ _____

Please print name of Patient, Parent, Guardian or Personal Representative Date

HIPAA Privacy Practices

After we have billed your insurance company, we will wait a reasonable amount of time for payment. You will be notified if your insurance will not cover all of even part of the account, or if it has been rejected by the insurance company. It is your responsibility to negotiate with your insurance company. The doctor is treating you, not your insurance company.

This office does require payment in full for **non-covered benefits** at the time services are rendered. If your situation is considered impossible, arrangements must be set up either in a bi-weekly or monthly basis.

We are members of a Finance System for collection purposes. If there is no attempt being made to pay the account, we have no alternative than to turn the account over to them. If payment is not made to the Bureau, in-full, the account will appear on your credit record.

There will be a $25 charge to all accounts for returned checks.

It is requested by our office that if you need to cancel or change an appointment that you do this by calling us 24 hours in advance. If you do not call or don't show up for an appointment, you will be charged a $20 fee for established patients or a $50 fee for new patients.

It is our policy at Family Foot & Ankle Centers, P.C. to contact our patient by phone the day before an appointment as a verification of the appointment date and time as a courtesy. Is it okay to leave a message on your answering machine or with whomever answers the phone with this information?
Circle one: YES NO

Also, if we need to speak to you directly, may we leave a message via answering machine or with whomever answers the phone or mail a request for you to contact the office?
Circle one: YES NO

Is there anyone that you **do not** want us to discuss your medical care or medical billing with?
Please give name and relationship:
_____

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read, if I so chose to) and understood the Notice.

_____ _____
Patient Name (Please Print) Date

_____
Parent or Authorized Representative (if applicable)

_____
Signature