



The Foot & Ankle Center

PATIENT INFORMATION

All information given is Confidential. Please fill out completely and sign below

First Name _____ MI _____ Last Name _____

SSN # _____ Birth Date _____ Age _____

SEX: Male Female

Address _____

City _____ State _____ Zip _____

Home Phone _____ Work _____ Cell _____

Email Address _____

MARITAL STATUS: Single Married Divorced Widowed

Employer Name _____ Occupation _____ Phone _____

Physician's Name _____ City _____ Phone _____

SPOUSE INFORMATION (OR PARENT IF MINOR)

Spouse /Parent Name _____

Employer _____ Phone _____

If Minor - RESPONSIBLE PARTY

Who is responsible for this account? _____ Relationship to Patient _____

Address _____ Phone # _____

Date of Birth _____ Social Security # _____

Employer _____ Occupation _____

Employer Address _____ Phone # _____

Nearest Person or Relative Not Living with You

Name _____ Relationship _____ Phone _____

Address _____

How did you hear about our facility? Sign Family Friend Doctor Internet Other _____

Phone Book (Please Circle which one): Yellowbook Hometown

Where did you find our Phone Number? If phone book, which one? _____

ACCIDENT OR INJURY INFORMATION

Date of Accident or Injury _____

Where the accident or injury took place _____

How Accident or Injury occurred _____

All information given above is true and correct to the best of my knowledge.

Signature of Patient or Legal Guardian _____ Date _____

INSURANCE INFORMATION

Note: Please Present your Insurance Card to Receptionist

PRIMARY INSURANCE

Insurance Name _____

Member ID # on Insurance Card _____

Group Number _____

Group Name _____

Policy Holder's Name _____

Policy Holder's Birth Date _____

SSN# _____

Relationship to Patient: Self Child Spouse

SECONDARY INSURANCE

Insurance Name _____

Member ID # on Insurance Card _____

Group Number _____

Group Name _____

Policy Holder's Name _____

Policy Holder's Birth date _____

SSN # _____

Relationship to Patient: Self Child Spouse

HMO Patients

YOU ARE RESPONSIBLE FOR YOUR OWN REFERRAL AND AUTHORIZATIONS.

Please make sure you know how many visits you have and how long they are good for. Most referrals are only good for 60 or 90 days. Please ask the receptionist before leaving or call the office to make sure your referral has not expired. If you do not have proper authorization to see the doctor, you, the patient, will be solely responsible for the cost of the visit.

All Patients

I, hereby authorize, The Foot & Ankle Center, to release any medical records or information necessary to process this claim and any future claims that I may have. I also authorize payment of medical benefits directly to the physician and or provider as long as I am a patient. If it is necessary to involve a third party collector or an attorney for payment of services, I will be responsible for all cost of collection in the event of default. I understand that I, the patient, have a contract with my insurance company, not the doctor, and if for some unforeseen reason there is a dispute with my claim, I, the patient, will be responsible for the cost of services given to me by The Foot & Ankle Center.

Signature _____ Date _____

PODIATRIC HISTORY

ALLERGIES:

- Adhesive Tape Aspirin Betadine Codeine Demerol Erythromycin
 Iodine Penicillin Quinolones Sulfa Local Anesthetics NONE
 Other _____

CURRENT MEDICATIONS:

Please list all medicines which you now use:

VITALS:

Current Weight _____ Current Height _____ What is your shoe size? _____

ACTIVITIES *(please list any activities that you participate in)*

EXERCISE

SOCIAL HISTORY

- Do You Drink Alcohol YES NO
Do You Smoke? YES NO
Recreational Drug Use YES NO

OCCUPATION: _____

- Employed Unemployed Retired Disabled Full Time Part Time

Name of Company _____

FAMILY HISTORY

Is there a Family History of any of these disorders?

- Arthritis Cancer Diabetes Gout Heart Trouble
 High Blood Pressure Kidney Mental Migraines Stroke

REVIEW OF SYSTEMS

Please indicate if you have any of the following:

General:	<input type="checkbox"/> Change in Appetite <input type="checkbox"/> Fever	<input type="checkbox"/> Chills <input type="checkbox"/> Night Sweats	<input type="checkbox"/> Fatigue <input type="checkbox"/> Weakness
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Cardiac:	<input type="checkbox"/> Chest pain <input type="checkbox"/> Heart Attack	<input type="checkbox"/> Feet Swell <input type="checkbox"/> Heart Murmur	<input type="checkbox"/> Hands Swell <input type="checkbox"/> Leg Pain
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Endocrine:	<input type="checkbox"/> Diabetic Type I	<input type="checkbox"/> Diabetic Type II	<input type="checkbox"/> Thyroid Problems
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GI:	<input type="checkbox"/> Abdominal Pain <input type="checkbox"/> Liver Trouble	<input type="checkbox"/> Gallbladder <input type="checkbox"/> Nausea	<input type="checkbox"/> Indigestion <input type="checkbox"/> Stomach Trouble
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Genitourinary:	<input type="checkbox"/> Bladder Trouble <input type="checkbox"/> Kidney Stones	<input type="checkbox"/> Frequent Urination <input type="checkbox"/> Prostate Trouble	<input type="checkbox"/> Kidney Disease
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Hematologic/Lymphatic:	<input type="checkbox"/> Anemia	<input type="checkbox"/> Excessive Bleeding	<input type="checkbox"/> Aspirin Use
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Musculoskeletal:	<input type="checkbox"/> Arthritis <input type="checkbox"/> Fractures <input type="checkbox"/> Sprains	<input type="checkbox"/> Back Pain <input type="checkbox"/> Joint Pain <input type="checkbox"/> Stiffness	<input type="checkbox"/> Bone Pain <input type="checkbox"/> Muscle Pain
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Neurologic:	<input type="checkbox"/> Dizziness <input type="checkbox"/> Paralysis	<input type="checkbox"/> Headache <input type="checkbox"/> Seizures	<input type="checkbox"/> Numbness /Tingling
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Peripheral Vascular:	<input type="checkbox"/> Blood Clots	<input type="checkbox"/> Cramps	<input type="checkbox"/> Varicose Veins
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Psychiatric:	<input type="checkbox"/> Depression	<input type="checkbox"/> Other _____	
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Respiratory:	<input type="checkbox"/> Asthma <input type="checkbox"/> Sinus Problems	<input type="checkbox"/> Lung Problems <input type="checkbox"/> TB Exposure	<input type="checkbox"/> Shortness of Breath
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Rheumatology:	<input type="checkbox"/> Fibromyalgia		
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Skin:	<input type="checkbox"/> Bruising <input type="checkbox"/> Itching <input type="checkbox"/> Skin Ulcerations	<input type="checkbox"/> Deformed Nails <input type="checkbox"/> Rashes	<input type="checkbox"/> Discoloration of nails <input type="checkbox"/> Scarring Tendencies
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Other:	<input type="checkbox"/> Hearing Loss	<input type="checkbox"/> Vision Loss	
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None of the above pertains to me.

MEDICAL HISTORY

Please indicate below what you have been diagnosed with by another Physician
This page is not a duplicate

Please list any previous Surgeries: _____

Cardiovascular: Angina High Blood Pressure Mitral Valve Prolapse
 Murmur Stroke

Endocrine: Diabetes * Date you were diagnosed _____
 * Name of your doctor treating you for Diabetes _____
 * Date you last saw your Doctor _____
 Your last A1C Level _____
 Hyperthyroid Hypothyroid Osteoporosis

Gastrointestinal: Cirrhosis Gallbladder Gastritis

Genitourinary: Prostate Renal Failure

HEENT: Cataracts Dizziness Macular Degeneration Sinusitis

Hematology: Deep Vein Thrombosis Coagulation Disorders

Infectious Disease: AIDS Abscess Hepatitis Osteomyelitis

Malignancy: Bladder Cancer Breast Cancer Gallbladder Cancer Leukemia
 Liver Cancer Lung Cancer Thyroid Cancer

Musculoskeletal: Back Pain Charcot Joint Reflex Sympathetic Dystrophy
 Sprain

Neurology: Alzheimer's Cerebral Palsy Headache Parkinson's Disease
 Seizures Stroke

Psychiatry: Anxiety Bipolar Depression

Respiratory: Asthma COPD Emphysema

Rheumatology: Fibromyalgia Gout Rheumatoid Arthritis

Skin: Psoriasis Eczema Lipoma

I certify that the above information is true and correct to the best of my knowledge. I give my permission to the doctor to administer and perform such procedures as may be deemed necessary in the diagnosis and/or treatment of my condition(s).

(Patient Signature)

Date

The Foot and Ankle Center

ACKNOWLEDGEMENT 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 choose) and understand the Notice.

Print Name of Patient

Signature of Patient, Parent or Authorized Representative

Date

The Foot and Ankle Center

FINANCIAL POLICY

Thank you for choosing The Foot & Ankle Center as your healthcare provider. We are committed to the successful treatment of your condition. Please understand that payment of your bill is considered part of your treatment. Should you have any questions regarding any aspect of your financial status with our office, please feel free to contact our billing dept at 618.344.4449.

Your clear understanding of our Financial Policy is important to our professional relationship.

WE ARE HAPPY TO BILL YOUR INSURANCE DIRECTLY; HOWEVER, WE MUST HAVE A COPY OF THE INSURANCE CARD.

IF YOU DO NOT HAVE YOUR INSURANCE CARD WITH YOU, FULL PAYMENT IS DUE AT THE TIME OF SERVICE. WE ACCEPT CASH, OR CREDIT/DEBIT CARD.

ALL PATIENTS MUST COMPLETE OUR "PATIENT REGISTRATION FORM" AND OTHER RELATED FORMS.

PLEASE NOTIFY US IMMEDIATELY OF ANY CHANGES IN YOUR INSURANCE OR COVERAGE.

SELF PAY Patients

We expect payment at the time of service unless prior arrangements have been made.

MEDICARE Patients

We accept Medicare assignment. As a Medicare patient, you are responsible only for the deductible if you have supplemental insurance. A few services and supplies are not covered by Medicare. We will advise you of any non-covered charge prior to the service being provided.

HMO/PPO Patients

ALL COPAYMENTS ARE DUE AT THE TIME OF SERVICE. We are members of most, but not all plans; you are responsible for verifying that we are providers for your plan. If you are an HMO member, you will not be billed as long as we have the necessary referrals. Please note: You must have your referral at the time of the visit or your plan requires that we ask you to reschedule. PPO patients will only be responsible for their deductible, co-payments and co-insurance, as long as they have verified with their insurance that our physician is in their plan.

WORKERS' COMPENSATION

If you are here because of a work related injury, we will require information regarding both health insurance and your employer's Workers' Compensation carrier authorizing your treatment. The letter should include the claim number, address, adjuster's name and phone number. (Your employer's human resource office should be able to assist you with obtaining this information). If payment is not received from the third party within 90 days, we have the right to bill you directly.

HOSPITAL AND SURGERY CENTER CHARGES

In the event that you undergo surgery in a hospital or ambulatory surgery center, a separate charge will be made by that facility. Your podiatric physician at The Foot & Ankle Center may have a financial interest in a surgery center where you will be having your surgery.

FINANCIAL AGREEMENT

I understand that I am financially responsible for all charges not covered by insurance and I guarantee the balance to be paid by my credit card, check or cash. Past due balances may be subject to additional fees.

I understand that if the office agrees to bill insurance as a courtesy, I must submit proper information as needed to ensure payment for services rendered to me. I understand that I am ultimately responsible for payment for all services. If payment is not received from the insurance carrier or other responsible party in 90 days, I will be billed directly.

I will pay unpaid balance by: _____Cash _____Check _____Credit Card

Name of Patient (please print)

Signature of Patient or Responsible Party

Date



Release of My Protected Health Information

Please **print** below information:

I, _____ hereby authorize release of my Protected health information for verbal discussion only of my care and treatment to the person(s) specified below:

Authorized family member or person to receive information for the above named patient's care:

Name of Central Contact, other than patient	Relationship to Patient	Phone Number

Others authorized to receive my verbal information (please list names and relationship):

Print Name	Relationship to Patient	Phone Number

Print Name	Relationship to Patient	Phone Number

NOTE: This form does give the above referenced persons permission to make health care decisions for the patient or entitle them to paper copies or electronic access of your medical record. We will not release via the telephone or any other means of communication any information to any friends or family members not listed above unless the patient has an opportunity to object and does not (documented), or if it is reasonable to infer that the patient does not object such as when a patient brings a spouse into the room when treatment is being discussed. Exception: if the release is needed in emergency situations.

- Leave message on answering machine or voice mail? Yes No
- Leave message for patient to return call? Yes No

Note: By signing and dating this Protected Health Information Authorized Person(s) form, I revoke all previously signed Protected Health Information Authorized Person(s) forms.

Patient Signature: _____ Date: _____

Personal Representative: _____ Relationship to Patient _____

Note: Except to the extent that action has already been taken in reliance on this Protected Health Information Authorized Person(s), at any time I can revoke this Protected Health Information Authorized Person(s) by submitting a new Protected Health Information Authorized Person(s) form or by written notice to The Foot & Ankle Center where my medical records are kept.