ANKLE & FOOT CLINIC, INC.

Patient Registration & History

1 PATIENT INFORMATION

TODAY'S DATE_____

PATIENT'S LAST NAME_____FIRST_____MIDDLE INITIAL_____

MAILING ADDRESS_____APT NO _____

CITY_____STATE_____ZIP CODE_____

HOME PHONE_____CELL PHONE_____

PATIENT E-MAIL ADDRESS_____

SEX:___M_____F AGE_____DATE OF BIRTH_____HEIGHT_____WEIGHT_____SHOE SIZE_____

SS#_____MARITAL STATUS: Single Married Widowed Separated Divorced

OCCUPATION_____EMPLOYER_____

EMPLOYER ADDRESS_____EMPLOYER PHONE_____

SPOUSE'S NAME/EMERGENCY CONTACT:_____PHONE: _____

NAME OF PARENT OR GUARDIAN (IF PATIENT IS A MINOR)_____

PARENT/GUARDIAN SS#_____PARENT/GUARDIAN DATE OF BIRTH_____

DO YOU HAVE A LIVING WILL?_____ IF YES, WHERE CAN THIS BE LOCATED?_____

2 REFERRAL INFORMATION - HOW DID YOU FIND OUT ABOUT US?

_____FAMILY MEMBER/FRIEND	_____NEWSPAPER	_____DR._____
_____TV/RADIO AD	_____INSURANCE BOOK	_____HOSPITAL
_____BUILDING SIGN	_____INTERNET/WEB SITE	_____PHONE BOOK

3 INSURANCE **PLEASE PRESENT YOUR INSURANCE CARD & DRIVER'S LICENSE TO THE RECEPTIONIST.

PRIMARY POLICY HOLDER'S NAME_____DATE OF BIRTH_____

SECONDARY POLICY HOLDER'S NAME_____DATE OF BIRTH_____

*(We gladly bill PRIMARY and SECONDARY insurances for you but it is your responsibility to submit to your tertiary if any)

4 CHIEF COMPLAINT What is the reason for which you came to be treated? _____

Duration of Problem_____Have you had previous treatments? □Yes □ No By Whom?_____

Is this a work related injury? □ Yes □ No What is the date of injury?_____

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5 MEDICAL HISTORY – Please indicate foot problems you now have or have had in the past.

Ankle pain	□ Yes	□ No	Heel Pain	□ Yes	□ No
Athlete's foot	□ Yes	□ No	Ingrown Toenails	□ Yes	□ No
Bunions	□ Yes	□ No	Plantar's Warts	□ Yes	□ No
Corns & Calluses	□ Yes	□ No	Swelling in Ankle or Feet	□ Yes	□ No
Flat Feet	□ Yes	□ No	Foot or Leg Cramps	□ Yes	□ No

Please list surgeries:_____

Hospitalizations: _____

Family Physician_____Date of last visit_____

Place a mark of "Yes" or "No" to indicate if you have had any of the following:

Aids/HIV	□ Yes	□ No	Diabetes	□ Yes	□ No	Phlebitis	□ Yes	□ No
Allergies to Anesthetics	□ Yes	□ No	Ear Problems	□ Yes	□ No	Psychiatric Care	□ Yes	□ No
Arthritis	□ Yes	□ No	Eye Problems	□ Yes	□ No	Rash	□ Yes	□ No
Artificial Joints/Valves	□ Yes	□ No	Family History/Diabetes	□ Yes	□ No	Shortness of Breath	□ Yes	□ No
Asthma	□ Yes	□ No	Gout	□ Yes	□ No	Sinus Problems	□ Yes	□ No
Back Problems	□ Yes	□ No	Headaches	□ Yes	□ No	Special Diet	□ Yes	□ No
Bleeding Disorders	□ Yes	□ No	Heart Disease	□ Yes	□ No	Stroke	□ Yes	□ No
Blood Clots	□ Yes	□ No	Hemophilia	□ Yes	□ No	Swollen Neck Glands	□ Yes	□ No
Cancer	□ Yes	□ No	Hepatitis or Jaundice	□ Yes	□ No	Tuberculosis	□ Yes	□ No
Chemical Dependency	□ Yes	□ No	High Blood Pressure	□ Yes	□ No	Ulcers	□ Yes	□ No
Chest Pain	□ Yes	□ No	Kidney Problems	□ Yes	□ No	Varicose Veins	□ Yes	□ No
Chronic Diarrhea	□ Yes	□ No	Liver Disease	□ Yes	□ No	Cigarette/Tobacco Use	□ Yes	□ No

6 MEDICATIONS – Include prescriptions, over-the-counter medications, and vitamins:

***PLEASE PROVIDE US WITH YOUR MEDICATION CARD/LIST IF YOU HAVE ONE**

Medications_____

_____

Preferred Pharmacy Name_____Pharmacy Phone # _____

7 ALLERGIES – Mark any that apply:

No Known Allergies	□				
Adhesive Tape	□ Yes	□ No	Latex	□ Yes	□ No
Anti-Inflammatory Meds	□ Yes	□ No	Local Anesthetics	□ Yes	□ No
Anticoagulant Therapy	□ Yes	□ No	Novocain	□ Yes	□ No
Aspirin	□ Yes	□ No	Penicillin	□ Yes	□ No
Codeine	□ Yes	□ No	Seafood	□ Yes	□ No
Cortisone	□ Yes	□ No	Sulfa	□ Yes	□ No
Demerol	□ Yes	□ No	Other …	_____	

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8 SIGNATURE ON FILE & PERMISSION TO TREAT

I request that payments of authorized benefits on my behalf for any services furnished me by Ankle & Foot Clinic, Inc. I authorize any holder of information about me to release any information needed to determine these benefits or the benefits payable to related services to the insurance agent. I recognize my financial obligation of any co-insurance, co-pays, or deductibles and non-covered services that may be required. I give permission to Ankle & Foot Clinic, Inc. to examine, photograph, administer, and perform such minor operative procedures as may be deemed necessary in the diagnosis and/or treatment of my foot and/or ankle problems.

Signed X_____Date_____

*PLEASE READ AND *INITIAL* THE FOLLOWING:

X_____ **9 FINANCIAL POLICY**

We are committed to providing you with the highest quality medical and surgical care. In return, we ask you to be equally committed to being fully responsible for paying our fees. This will help in reducing our billing and administrative burdens, leaving more time for helping you. This dual commitment is the foundation of our relationship. Our goal is to maximize the quality of your care and minimize misunderstandings regarding fees and payment. **To ensure quality communication, it is the patient's (and/or guardian's) responsibility to inquire about fees/insurance coverage prior to any service being performed.** We accept many different insurance plans, however all plans are not the same and do not cover the same services. ***Please note: It is the responsibility of each patient to know his or her contract limitations. Specifically, if your policy requires a written referral prior to your visit, it is the patient's responsibility to obtain that referral (or have it sent to our office) prior to making an appointment at Ankle & Foot Clinic, Inc.***

- **Managed Care Patients/Private Insurance**
  If you are in a managed care plan (HMO, PPO, IPA) with whom we participate, we abide by our contract with them. In either managed care plans or private plans, we will bill your insurance company; however you are responsible for paying any Co-pays, coinsurance, and deductibles required by your plan at the time of treatment.
- **Medicare Patients**
  We accept assignment for Medicare: that does not mean that all services are covered. Patients are responsible for paying their annual deductible if it has not yet been met. You are also responsible for any co-payments, which are usually 20% of the allowed amount for an item or service. (This may be covered by a secondary insurance)
- **Uninsured Patients**
  A minimum payment of $100.00 in the form of cash, check, or credit card is due at the time of service.
- **All Patients**
  For your convenience, we accept Visa, MasterCard, Discover, cash or check. There is a $25 service fee for all returned checks.

X_____ **10 COMPLETION OF FORMS POLICY**

The Physician is often asked to complete a variety of forms outside of their visit. Completing a form requires time from the Physician's day to review the chart and complete the forms accurately. Therefore, we do charge a nominal fee for this service. The fee can range from $10.00-$25.00 depending on the forms, which must be paid prior to the forms being filled out.

X_____ **11 DURABLE MEDICAL EQUIPMENT POLICY**

It is the policy of this office to help obtain insurance benefits regarding a patient's individual coverage of these items. This is a courtesy, which we are happy to provide; however, Ankle & Foot Clinic, Inc. is **not** responsible for the accuracy of the information received. Information received by phone is not a guarantee of payment and if any doubt exists as to eligibility, it is highly recommended that you check your plan booklet for a detailed outline of your benefits or make a personal phone call to your insurance company. ***Please note, if these items are denied by insurance due to coverage limitations, the patient hereby accepts responsibility for the cost.***

X_____ **12 PRIVACY STATEMENT**

Ankle & Foot Clinic, Inc. will only use and disclose your health information for the following purposes: to treat you, to assist other health care providers in treating you, to allow insurance companies to process insurance claims for services rendered to you, to obtain payment for services rendered to you and for certain limited operation activities, such as quality assessment, licensing, accreditation and training of students. Except as stated in more detail in the Notice of Privacy Practices, we will not use or disclose your health information without your written authorization.

Acknowledgement of Receipt of Notice of Privacy Practices: (My *initials above represent that I have been offered a copy of the policy)*