PATIENT INFORMATION

Welcome to Center for Ankle and Foot Care
Dr. Michele McGowan and Dr. Timothy Henne

We are pleased to welcome you to our office. Please take a few minutes to fill out these forms as completely as you can. If you have questions we'll be glad to help you.

Last Name _____ First Name _____ Middle Initial _____ Date _____

Soc. Sec. #_____ Driver's License # _____

Address_____ City_____ State _____Zip_____

Home Phone_____ Cell Phone_____ Work Phone_____

Mailing Add (if different) _____ Email add_____

Sex ❑M ❑F Age _____ Birth Date ____/____/____ Single___ Married___ Widowed ___ Divorced___ Other ___

Patient employed by _____ Occupation _____

May we call you at work? ❑Y ❑N Work Hours _____ Work Phone_____

Business Address _____

Notify in case of Emergency _____ Relationship to patient _____

Home Phone_____ Cell phone_____ Business phone _____

How did you hear about us? News Leader❑ Channel 13 News❑ Google❑ ERGent Care ad❑ Epic Movies❑

Ins Comp❑ Internet search❑ Patient ❑Dr. _____ Other_____

INSURANCE INFORMATION (If no card is available to copy)

Primary Insurance

Insurance Company _____ **Phone #**_____

Contract # _____ **Group #** _____ **Subscriber #** _____

Person responsible for account _____ DOB _____/_____/_____

Relation to patient _____ Soc. Sec # _____ Home phone_____

Address (if different from patient)_____

Person responsible employed by _____ Occupation _____

Business Address _____ Business phone _____

Additional Insurance

Is patient cover by additional insurance? _____Yes _____ No

Secondary Insurance Company _____ **Phone #**_____

Contract # _____ **Group #** _____ **Subscriber #** _____

Person responsible for account _____ DOB _____/_____/_____

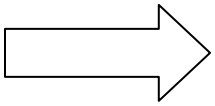
Relation to patient _____ Soc. Sec # _____ Home phone_____

Insurance Company _____ **Phone #**_____

Contract # _____ **Group #** _____ **Subscriber #** _____

Person responsible for account _____ DOB _____/_____/_____

Relation to patient _____ Soc. Sec # _____ Home phone_____



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PATIENT INFORMATION

Family Physician Name _____ Last Visit _____

Address_____ Phone # _____

What is the nature of your Foot problem? _____

_____

Height _____ Weight _____ Shoe Size _____ Last blood pressure count ____/____

Are you in good general health? ❑Y ❑N If no, explain _____

_____

Are your feet tired at the end to the day? ❑Y ❑N

Do you have lower back pain? ❑Y ❑N

Have you ever broken a bone in you foot or ankle? ❑Y ❑N

Have you had previous foot/ankle surgery? ❑Y ❑N

Do you use tobacco products? ❑Y ❑N

If yes, what amount daily? _____

_____

MEDICAL HISTORY

Check if you have had any of the following:

❑Arthritis, Rheumatism
❑Asthma
❑Bleeding disorder
❑Eye trouble
❑Cramps/Numbness in feet or legs
❑Swelling of feet or Ankles
❑Diabetes
❑Heart trouble
❑Kidney trouble
❑Liver trouble
❑Varicose Veins
❑High blood pressure

List any other Medical problems:

_____

_____

_____

Are you Allergic/sensitive to:

❑Anesthetics ❑Novocaine ❑Sulfa Drugs
❑Drugs ❑Penicillin ❑Latex
❑Foods ❑Tape
❑Materials ❑Other_____

List of Surgery: _____

_____

_____

_____

List of Medications you are currently taking, if any:

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

Authorization

I have reviewed the information on this questionnaire and it is accurate to the best of my knowledge.
I understand that this information will be used by the doctor to help determine appropriate treatment. If there is any change in my medical status, I will inform the doctor.
I authorize my insurance company to pay the doctor or medical group all insurance benefits otherwise payable to me for services rendered. I authorize the use of this information on all insurance submissions.
I authorize the doctor to release all information necessary to secure the payment of benefits.
I understand that if I am in default of payment, I will be responsible for any attorney or collections fees.

Signature _____ **Date**_____

MEDICARE LIFETIME SIGNATURE ON FILE

I request that payment of authorized Medicare benefits be made either to me or on my behalf to the Center for Ankle and Foot Care, Inc. for any services furnished me by the physicians. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or benefits payable for related services.

SIGNATURE_____ **DATE**_____

SECONDARY INSURANCE
I understand that my secondary claim is billed as courtesy only and will be submitted to the appropriate party ONE TIME. After that one time submission if the insurance company does not pay within 60 days or denies the claim, I (the patient) will be financially responsible to pay.

SIGNATURE_____ **DATE**_____

PATIENT AGREEMENT
I understand that payment is due at the time of service, including co pays and/or deductible. I certify that the information provided on this form is correct. I authorize the release of information including medical information to this organization and all insurance organizations involved with my claim. I understand that if I am in default of payment, I will be responsible for any attorney or collections fees. I authorize my physician to prescribe medication and to give me reasonable and proper medical care by today's standards.

SIGNATURE_____ **DATE**_____

ACKNOWLEDGE 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) and understand the Notice.

_____ _____
Patient Name (please print) **Date**

_____
Parent or Authorized Representative (if applicable)

_____
Signature

Discussion of medical treatment

Patient Name: _____ Date_____
List the family members or other person, if any, whom we can discuss you medical condition and your diagnosis to. (Your social security Number must be known to this person in order for them to access confidential information)

Name:_____ Relationship to you_____

Name:_____ Relationship to you_____

Name:_____ Relationship to you_____

Name:_____ Relationship to you_____