PATIENT INFORMATION

Welcome to Center for Ankle and Foot Care

Last Name ________________ First Name ____________________ Middle Initial ____ Date ______________

Soc. Sec. #_________________________________ Driver's License # ________________________

Address_____________________________________ City___________________ State ___________Zip____________

Home Phone_____________________ Cell Phone_____________________

PLEASE LIST YOUR EMAIL ADDRESS FOR THE PATIENT PORTAL_________________________________

Sex ❑M ❑F Age ________ Birth Date ____/____/____

Notify in case of Emergency ______________________________ Relationship to patient _______________________

Home Phone_____________________ Cell phone_______________________ Business phone __________________

How did you hear about us? News Leader❑ Google❑ Ins Comp❑ Internet search❑ Patient

❑Dr. ______________ Other_____________

INSURANCE INFORMATION

Primary Insurance

Insurance Company ____ **Phone #**__________________________

Contract # __________________________ **Group #** ______________________ **Subscriber #** ______________________

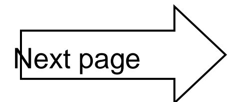
Person responsible for account ____ DOB _____/_____/_____

Relation to patient ________________________ Soc. Sec # _____________________ Home phone_____________________

Address (if different from patient)____

Person responsible employed by ___________________________ Occupation ____________________________

Business Address _____________________________________ Business phone __________________________



PATIENT INFORMATION

Family Physician Name ____ Last Visit __________________________

Address____ Phone # ______________________________

What is the nature of your Foot problem? ____

____

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
❑Drugs
❑Foods
❑Materials
❑Novocaine
❑Penicillin
❑Tape
❑Other______________
❑ Sulfa Drugs
❑ Latex

List of Surgery: ___________________________

____

____

____

List of Medications you are currently taking, if any:

______________________________ ___________________________ _________________________

______________________________ ___________________________ _________________________

______________________________ ___________________________ _________________________

______________________________ ___________________________ _________________________

Authorization For Billing and Payment

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_____________________________