

Account No. _____

NP ___ PCP ___ Notes _____



PATIENT INFORMATION:

Patient Name: (First) _____ (Initial) _____ (Last) _____

Mailing Address: _____ City _____ State _____ Zip _____

Phone: (____) _____ Cell Phone(____) _____ Date of Birth ____/____/____ Age _____

Sex: Male ___ Female ___ E-mail Address _____ Social Security No. _____

Height: _____ Weight: _____ Marital Status: Single ___ Married ___ Divorced ___ Widow ___ Student ___

Patient's Employer: _____ Business Phone: _____

Spouse/Parent: _____ Spouse's Employer: _____

Emergency Contact Outside of Home: _____

ADDRESS: _____ CITY: _____ ZIP: _____

PHONE: (____) _____ Relationship: _____

Referred By (How did you hear about us?): _____

Primary Care Physician: _____ Send Report? Yes ___ No ___

Clinic Address: _____

City: _____ State _____ Zip _____ Phone _____ Fax _____

Are you being seen as a result of an accident? Yes: ___ No: ___ If yes, the following information is required:

Date of Accident: ____/____/____ Claim # _____ Case Worker _____ Phone: _____

PERSON RESPONSIBLE FOR BILL: (if other than patient, i.e. parent/spouse/guardian) Note to Divorce Parents: Parent or Guardian who presents with child for treatment will be responsible for all charges incurred.

Primary Insurance

Secondary Insurance

Ins. Name _____

Ins. Name _____

Policy # _____ Group# _____

Policy # _____ Group# _____

Subscriber Name _____

Subscriber Name _____

Subscriber's Date of Birth ____/____/____

Subscriber's Date of Birth ____/____/____

Subscriber's relationship to Patient _____

Subscriber's relationship to Patient _____

Claims Address _____

Claims address _____

_____ Phone# _____

_____ Phone# _____

I hereby give Francis J. Clark, DPM, and/or Jason Dickerson, DPM, and/or Michael K Lowe, DPM, and/or Val G Mullinax, DPM, and/or Stanley J. Phillips, D.P.M. and/or S. Thomas Schiffgen ,D.P.M. and/or Stanton M. Smith, D.P.M. and/or Doug Stoker, D.P.M. permission to examine and treat my lower limbs.

I,undersigned patient or guardian, agree to pay the customary charge for all services in full, at the time of services, unless other written arrangements are made with and signed by the staff. In the event that my insurance carrier is billed for service rendered, I authorize payment of medical benefits directly to the Foot & Ankle Institute, and/or the treating doctor(s). In the event that my insurance carrier reduces benefits due to deductible and copayments, or if the customary charges are more than those allowed under my insurance plan, I agree to pay the difference within 30 days following notification. Although customary charges will be billed for all services rendered, they may be adjusted at the time of insurance payment according to the agreement Foot & Ankle Institute has with the insurance companies with which it participates. I authorize release of any medical information necessary to process the claim. In the event of default on this agreement, I agree to pay any and all reasonable and customary collection fees, including attorney fees and/or court fees. I understand that interest charges may be assessed at the rate of 1.5 percent per month, before and after judgment, on any amount past due. I am responsible for a \$10 fee on all returned checks. I also agree to pay a \$10 billing charge on all co-pay fees due as per my insurance agreement when not paid at the time of service.

_____(please initial) I acknowledge that I was provided a copy of the Notice of Privacy Practices, that I have been provided ample opportunity to read, and I understand and agree with the said Notice.

PATIENT'S or MINOR GUARDIAN'S SIGNATURE: _____ DATE: _____

PATIENT HISTORY

ALLERGIES:

Adhesive Tape	Y	N	Foods	Y	N
Antibiotics	Y	N	Morphine	Y	N
Aspirin	Y	N	Penicillin	Y	N
Chemicals	Y	N	Sulfa Drugs	Y	N
Codeine	Y	N	Latex	Y	N
Other Drugs	Y	N	_____		

Has anyone in your family (Mother, father, siblings, grandparents, aunt, uncle, etc.) had any of the following? If so, who?

- Arthritis _____
- Birth Defects _____
- Cancer (what kind?) _____
- Diabetes _____
- Heart Attack _____
- High Blood Pressure _____
- Osteoporosis _____
- Stroke _____

If Female, ARE YOU PREGNANT? Yes No
 Do you drink alcohol? Yes No
 Do you smoke? Yes No
 If Yes, Packs per Day _____ # of years _____
 Do you chew tobacco? Yes No
 Do you use recreational drugs? Yes No

Please list all surgeries you have had along with the approximate dates:

Please list all medications you are presently taking:

Please circle those YOU have been treated for:

HEART: Rheumatic Fever, Murmur, Chest Pain, Heart Attack, Angina, Congestive Heart Failure, Hypotension, Hypertension, Heart Disease

SKIN: Lesions, Moles, Eczema, or Rashes, Cancer

ENDOCRINE: Diabetes, Hypoglycemia, Thyroid Dysfunctions

GASTROINTESTINAL: Ulcers, Hiatal Hernia, Reflux, Diverticulitis, Diarrhea, IBS

BLOOD: Anemia, Bleeding Tendencies, Blood Clots.

LIVER: Hepatitis or Liver Dysfunction

MUSCULO-SKELETAL: Serious injuries, Back Problems, Deformities, Loss of Strength, Joint Pain, Osteoarthritis, Rheumatoid Arthritis, Lupus, Cramps

NEUROLOGIC: Depression, Weakness, Numbness, Stroke, Seizures, Migraines, Nervous Condition

LUNGS: Asthma, Pneumonia, Shortness of Breath, Emphysema, Pulmonary Embolism

KIDNEYS: Kidney, Bladder, or Prostate problems

OTHER: _____

What is your foot problem? _____

Date of Onset: _____

Describe any accident or event _____

When was the first visit to a doctor for this problem?
