Patient Information

Name: _____

Date of Birth: ___/___/_____ Age:

Social Security #: _____

Mailing Address: _____

_____

Employer/Occupation: _____

Home Phone: (_____)_____

Cell Phone: (_____)_____

Work Phone: (_____)_____

Pharmacy: _____

Email : _____

Race: **(Circle one)**

American Indian **Asian** **Black** **White** **Native Hawaiian / Islander**

Ethnicity - Do you consider yourself Hispanic/Latino **YES** **NO**

Primary Care Doctor: _____

How did you hear about our office?

Friend/Family

Other Doctor

Radio

Online

Other: _____

Emergency Contact / Guarantor Information

Full Name: _____

Mailing Address: _____

_____

Phone Number: (_____)_____

Relationship to patient: _____

Date of Birth: _____ Social Security#: _____

Is this the Guarantor for the patient: **YES** **NO**

If you would like for Ankle and Foot Surgical and Podiatry Clinic to file your insurance claim please provide your insurance card(s) along with a photo ID. Without your card your claim can not be filed. Payment is due in full at the time you are seen, unless other arrangements have been made with our business office.

By signing below I am authorizing Ankle and Foot Surgical and Podiatry Clinic to release all medical information necessary to process my insurance claim. I authorize payment of insurance benefits to be made to Ankle and Foot Surgical and Podiatry Clinic, unless my account is paid in full. I also understand it is my responsibility to know my insurance benefits and to ensure the following: Provider participation with my insurance policy, and obtaining all proper authorizations from Primary Care Providers when necessary.

_____

Signature Patient/Guarantor **Date**

Notice of Privacy Policies

Privacy Practices are posted in lobby area* Extra copies of Privacy Practices are available at our check in window

I acknowledge I was offered and/or provided a copy of the Notice of Privacy Practices and have read (or have had the opportunity to read) and understand the notice.

_____

Signature **Date**

Under certain circumstances Ankle and Foot Surgical and Podiatry Clinic may need to contact you regarding your healthcare needs, or with questions about your account or insurance. If you are not available may we leave a message on your answering machine?_____ Is there a person you would like to designate for Ankle and Foot Surgical and Podiatry Clinic to be able to discuss your medical condition, allow to pick-up paper work or prescriptions for you, or be able to discuss your insurance claim/account information with?

If **YES**, Whom?

_____

Full Name and Relationship

_____

Mailing Address

_____

Contact Phone Number(s)

_____

Patient/Guarantor Signature **Date**

No-Show Appointment Policy

Patient Name: _____

Dear Patient:

Thank you for choosing Ankle and Foot Surgical and Podiatry Clinic for your health care needs. We are committed to providing you with quality care.

If you are unable to keep your scheduled appointment(s), you need to contact our office (910)295-7400 at least 24 hours in advance. Cancellations without at least 24 hours notice may be charged a no-show fee of $50.00.

Cancellation in advanced allows your appointment time to be offered to other patients who may have an urgent healthcare need. We appreciate your understanding.

Your signature below indicates you have read and understand the Ankle and Foot Surgical and Podiatry Clinic no-show appointment policy.

_____

Patient Signature **Date**

_____

Witness Signature **Date**

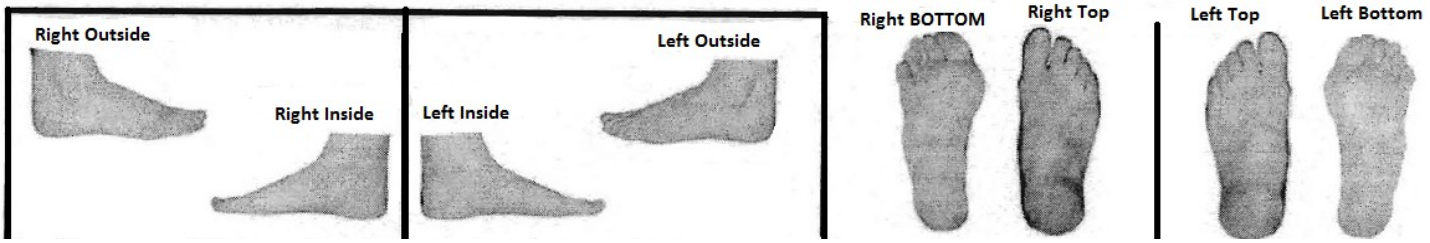
Ankle & Foot SURGICAL PODIATRY CLINIC

Patient History and Physical Sheet

Name: _____

Sex: Male / Female **Date of Birth:** _____ Age: _____

Shoe Size: _____ **Height:** _____ **Weight:** _____**lbs**



1. **Please mark the location of your problems on the above diagrams with an 'X'**
2. When did your problem start? _____
3. Describe the problem and the cause, if you know:

   _____
4. Circle all below that describe to your pain:

Burning **Shooting** **Sharp** **Aching** **Throbbing** **Numbness** **Tingling** **Dull**

5. What makes the problem worse? _____
6. List previous medical treatments or home remedies: _____
7. Anything else we should know?: _____

Are you DIABETIC? **Yes** **No** **If yes, for how long?** _____

Past Medical History: (Check the applicable boxes)

- ☐ DIABETES
- ☐ High Blood Pressure
- ☐ Circulation
- ☐ Phelbitis
- ☐ Gout
- ☐ Cancer
- ☐ Asthma
- ☐ Stomach Problems
- ☐ Liver
- ☐ Osteoarthritis
- ☐ Kidney Disease
- ☐ Alcoholism

Past Surgical History: _____

_____

Artificial Joints: _____ Anesthesia Complications: _____

Family History: (Is there a Family History of any of these disorders? Check the applicable boxes)

- ☐ Tuberculosis
- ☐ Kidney Disease
- ☐ Mental Illness
- ☐ Migraines
- ☐ Heart Attack
- ☐ Spinal Disorder
- ☐ Hypertension
- ☐ Other: _____
- ☐ Cancer
- ☐ Gout
- ☐ Arthritis
- ☐ Epilepsy
- ☐ Diabetes
- ☐ Alcoholism

Social History: (Check the applicable boxes)

- ☐ Married
- ☐ Use of Tobacco
- ☐ Single
- ☐ Use of Alcohol
- ☐ Divorced
- ☐ Use of illicit drugs

Employer/Occupation: _____ Years of School: _____ Degrees: _____

Current Medications: (List ALL medications below, including dosages)

_____

Allergies: (Check the applicable boxes)

- ☐ Penicillin
- ☐ Sulfa Drugs
- ☐ Aspirin
- ☐ Chemicals _____
- ☐ Morphine/Demerol _____
- ☐ Antibiotics _____
- ☐ Codeine
- ☐ Adhesive Tapes _____
- ☐ Foods _____
- ☐ Other Drugs _____
- ☐ Other _____

Allergic Reactions to these: _____