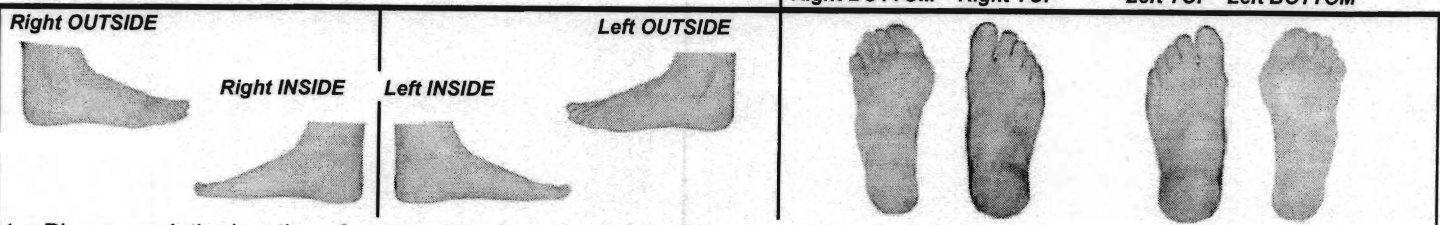
PATIENT INFORMATION SHEET

DATE: ____________________

NAME: ____________________ Race:________ Sex: Male/Female Date of Birth __________ Age:____



1. Please mark the location of your problem's on the **"above"** diagrams with an **"X"**
2. When did your problem start?____________________
3. Describe your foot problem and the cause, if you know:____________________
4. Circle all that applies 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: ____________________

SHOE SIZE: __________ **Height:** __________ **Weight:** __________

ARE YOU *DIABETIC*: (check) Yes ☐ No ☐

If *YES*, how long have you been diagnosed? ____________________

Past Medical History: (check if applicable)

- ☐ **DIABETES**
- ☐ High Blood Pressure
- ☐ Circulation
- ☐ Osteoarthritis
- ☐ Other ____________________
- ☐ Phlebitis
- ☐ Gout
- ☐ Cancer
- ☐ Kidney
- ☐ Asthma
- ☐ Stomach Problems
- ☐ Liver
- ☐ Alcoholism

Surgical History:

____

Do you have Artificial Joints?__________

Have you had any Anesthesia Complications? __________

Explain: ____________________

Family History (check if applicable)

☐ ***Is there a Family History of any of these disorders?***

- ○ Tuberculosis
- ○ Epilepsy
- ○ Gout
- ○ Hypertension
- ○ Alcoholism
- ○ Heart Attack
- ○ Kidney Disease
- ○ Diabetes
- ○ Allergies
- ○ Migraines
- ○ Cancer
- ○ Spinal Disorder
- ○ Mental Illness
- ○ Arthritis
- ○ Other ____________________

Social History (check if applicable)

- ☐ Marital Status/Living Arrangement ○ Single ○ Married ○ Other
- ☐ Use of Tobacco/Alcohol/Drugs ○ Tobacco ○ Alcohol ○ Drugs
- ☐ Current Employment/Occupation: ____________________
- ☐ Level of Education ○ Years of School __________ ○ Degrees __________

Current Medications: **(please list ALL medications below or ATTACH a list of you medications):**

____

☐ **ALLERGIES** (**◉ if applicable)**

- ○ **Penicillin**
- ○ Sulfa Drugs
- ○ Aspirin
- ○ Codeine
- ○ Morphine/ Demerol __________
- ○ Antibiotics __________
- ○ Other Drugs __________
- ○ Other Forms of Allergies
- ○ Adhesive Tapes __________
- ○ Any Foods __________
- ○ Any Chemicals __________

What kind of allergic reactions do you have to these medications? ____________________

Please Complete Back

Ankle and Foot Surgical and Podiatry Clinic

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 and Foot Surgical and Podiatry Clinic

Patient Information

Name: ____

Date of Birth: ____________________ Age: ____________

Mailing Address: ____

____

Home Phone: (______) ______________ Cell Phone: (______) ______________

Work Phone: (______) ______________ Email : ______________________

Social Security #: ____

Primary Care Doctor: ____

Who referred you to our office: ________________________________

Occupation: ____________________ Employer: ____________________

Pharmacy: ____

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

Please Complete Back

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**