



Patient Information

Name: _____

Date of Birth: ____/____/____

Social Security #: _____

Mailing Address: _____

City, State, Zip Code: _____

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**

Referring Doctor/

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, website, and in the patient portal*
Extra copies of Privacy Practices are available upon request**

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

Signature

Date

The practice may need to contact you to discuss treatment, insurance, and billing questions. We may leave a message on your answering machine asking for you to call us back.

If you are unavailable, whom would like to designate for our clinic to discuss your medical condition, allow to pick up paper work / prescriptions for you, or be able to discuss your insurance claim/account information?

Alternate Contact Name (if desired)

Relationship

Mailing Address

Alternate 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



Patient History and Physical Sheet

Name: _____

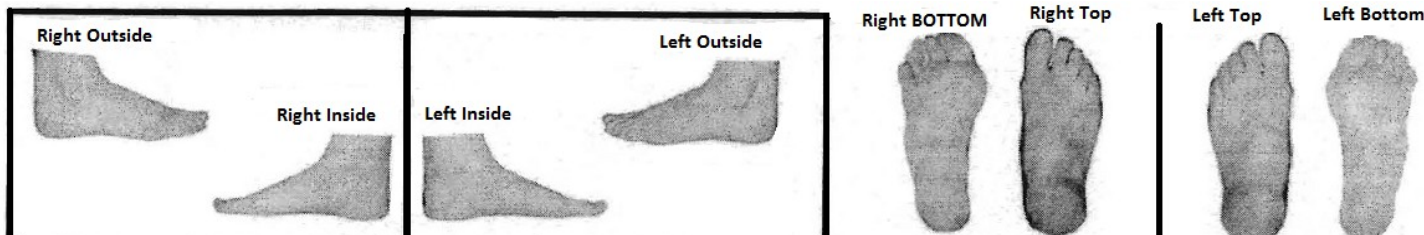
Sex: Male / Female

Date of Birth: _____

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	Phlebitis	Asthma	Osteoarthritis
High Blood Pressure	Gout	Stomach Problems	Kidney Disease
Circulation	Cancer	Liver	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	Heart Attack	Cancer	Epilepsy
Kidney Disease	Spinal Disorder	Gout	Diabetes
Mental Illness	Hypertension	Arthritis	Alcoholism
Migraines	Other: _____		

Social History: (Check the applicable boxes)

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

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

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

Allergies: (Check the applicable boxes)

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

Allergic Reactions to these: _____

**ANTHONY HARO III, DPM**

Diplomate, American Board of
Foot and Ankle Surgery
Certified in Reconstructive
Rearfoot/Ankle Surgery & Foot Surgery
Fellowship in Reconstructive
Foot and Ankle Surgery

AMIE L. HARACZ, DPM

Diplomate, American Board of Foot
and Ankle Surgery
Certified in Foot Surgery
Qualified in Reconstructive Rearfoot/
Ankle Surgery

KEVIN W. SCHMIDTKE, DPM

Diplomate American Board of
Foot and Ankle Surgery
Board Qualified in Foot
Surgery, Associate American
College of Foot & Surgery

RECORDS REQUEST

DATE: _____

TO: _____

I, _____ AUTHORIZE THE ABOVE MENTIONED TO RELEASE MEDICAL
RECORDS TO THE FOLLOWING:

___ Dr. A. Anthony Haro III ___ Dr. Amie Haracz ___ Dr. Kevin Schmidtke

Other: _____

THE MEDICAL RECORDS RELEASED SHOULD INCLUDE THE FOLLOWING:

_____ OFFICE NOTES	_____ OPERATIVE REPORTS
_____ LABORATORY PROCEDURES	_____ INSURANCE INFORMATION
_____ XRAY REPORTS	_____ PRESCRIPTIONS
_____ XRAY DISC (\$15)	___ OTHER: _____

PATIENT NAME: _____ DOB: _____

PATIENT SIGNATURE: _____

WITNESS: _____

(OFFICE STAFF SIGNATURE REQUIRED)

200 WESTGATE DRIVE SUITE A, WEST END, NC 27376
PHONE (910) 295-7400 FAX (877) 295- 0079

For personal requests: By signing this request I authorize Ankle and Foot Surgical and Podiatry Clinic, PA to release a copy of my medical records to me. By doing so, I understand the clinic and its staff will no longer be responsible for the confidentiality of the medical records provided and any redisclosure of these records may no longer be protected by federal or state law. Contact number for records pick up: _____

By submitting this medical record request, you acknowledge and agree that the information will be used solely for the specified purpose, subject to applicable laws. While we strive to protect the confidentiality of your records, we cannot guarantee absolute security. You authorize the release of records to designated recipients, understanding the potential sensitivity of the information. Ankle & Foot Surgical & Podiatry Clinic is not liable for any damages arising from the release or use of records. This authorization will expire one year from the date above.