ADVANCED FOOT & ANKLE CENTER

Welcome to Our Office

PATIENT INFORMATION

Patient _____
Last Name First Name Middle Initial

Address _____ _____
Street P.O. Box

_____
City State Zip

Mark the preferred **contact number:**

◯ **Home** (_____)_____ ◯ **Work** (_____) _____

◯ **Cell** (_____) _____

E-mail_____
*Used for appointment reminders, newsletters, billing inquiries and the Patient Portal.

Marital Status: ◯ Single ◯ Married ◯ Widowed ◯ Divorced

Sex: ◯ M ◯ F **Age**_____ **Birth Date**_____
MM/DD/YYYY

Social Security Number_____
***Required:** Medicare, Medicaid, or Military

Preferred Language? _____

Ethnicity or Race:
☐ Hispanic/Latino ☐ American Indian/Alaska Native
☐ Asian ☐ Black or African American
☐ Native Hawaiian or other Pacific Islander
☐ White ☐ Other race

Occupation_____

Employer _____

Spouse's Name _____

Spouse's Employer_____

BILLING ADDRESS (If different than above)

_____ _____
Street P.O. Box

_____
City State Zip

EMERGENCY CONTACT (Not in your household)

Name _____

Relationship _____

Home (_____) _____

Cell (_____) _____

RESPONSIBLE PARTY (For Minors)

Name _____ **DOB** _____

Relationship to Insured _____

Phone (_____) _____

Cell (_____) _____

PHYSICAL INFORMATION

Height _____**Weight** _____

Shoe Size_____

Do You Have Diabetes?
◯ Yes ◯ No

If you have Diabetes, fill out the following questions?

Last A1c value _____

Last Blood Sugar Reading _____

MEDICATIONS

Do you presently take any medications? ◯ Yes ◯ No

If yes, please list all current medications; include prescriptions, over-the-counter, herbs and vitamins.

_____

_____

_____

_____

_____

Do you take oral contraceptives? ◯ Yes ◯ No

ALLERGIES

☐ **No Known Drug Allergies**
☐ Adhesive Tape
☐ Anticoagulant
☐ Aspirin
☐ Codeine
☐ Latex
☐ Iodine
☐ Local Anesthetic
☐ Novocaine
☐ Penicillin
☐ Sea Foods
☐ Sulfa

☐ Other_____

PREFERRED PHARMACY

Pharmacy Name _____

Address _____

City, State _____

Phone _____

SOCIAL HISTORY

Do you exercise? ◯ No ◯ Seldom ◯ 1-3 times a week ◯ 3-5 times a week ◯ 6+ times a week

Do you drink alcohol? ◯ Yes ◯ No

Tobacco Use: ◯ **NON-SMOKER**

◯ Never Smoked

◯ Former Smoker

How many years?_____

◯ **SMOKER**

Pick the one th`at best applies

◯ Current Every Day Smoker

◯ Current Some Day Smoker

◯ Heavy Tobacco Smoker

◯ Light Tobacco Smoker

How many years?_____

Pick the one that best applies

Smoked Per Day:

◯ Less than 1 ◯ 20 to 30

◯ 1 to 9 ◯ 40 or more

◯ 10 to 19

SURGICAL HISTORY

Have you had a surgery? ◯ Never ◯ Yes *(fill in the rest of the section)*

List any **surgeries** you have had _____

_____

Have you ever had an **infection** after surgery? ◯ Yes ◯ No If yes, please explain _____

_____

Have you had any **complications** from surgery? ◯ Yes ◯ No If yes, please explain_____

_____

List any **hospitalizations** other than the surgeries listed _____

_____

BLOOD FAMILY HISTORY

	Mother	Father	Sister	Brother	Daughter	Son
Arthritis	☐	☐	☐	☐	☐	☐
Asthma	☐	☐	☐	☐	☐	☐
Complications from Anesthesia	☐	☐	☐	☐	☐	☐
Dementia	☐	☐	☐	☐	☐	☐
Depression	☐	☐	☐	☐	☐	☐
Diabetes – Type I / Type II	☐☐	☐☐	☐☐	☐☐	☐☐	☐☐
Heart Disease	☐	☐	☐	☐	☐	☐
High Blood Pressure	☐	☐	☐	☐	☐	☐
High Cholesterol	☐	☐	☐	☐	☐	☐
Kidney Disease	☐	☐	☐	☐	☐	☐
Obesity	☐	☐	☐	☐	☐	☐
Osteoporosis	☐	☐	☐	☐	☐	☐
Stroke	☐	☐	☐	☐	☐	☐
Substance Abuse	☐	☐	☐	☐	☐	☐

	Mother	Father	Sister	Brother	Daughter	Son
Breast Cancer	☐	☐	☐	☐	☐	☐
Colon Cancer	☐	☐	☐	☐	☐	☐
Lung Cancer	☐	☐	☐	☐	☐	☐
Skin Cancer	☐	☐	☐	☐	☐	☐
Stomach Cancer	☐	☐	☐	☐	☐	☐
Thyroid Cancer	☐	☐	☐	☐	☐	☐
Ovarian Cancer	☐	--	☐	--	☐	--
Uterine Cancer	☐	--	☐	--	☐	--
Prostate Cancer	☐	☐	--	☐	--	☐
Testicular Cancer	--	☐	--	☐	--	☐

PODIATRIC HISTORY

What is the chief reason for being seen today?_____

Is this condition the result of an on the job injury? ◯ Yes ◯ No

If yes, please explain _____

Which foot/ankle? ◯ Right ◯ Left ◯ Both

Quality of ailment: *(Mark all that apply)*

☐ Aching ☐ Burning ☐ Constant ☐ Crushing ☐ Disabling ☐ Dull ☐ Inconsistent
☐ Sharp ☐ Pulling ☐ Stabbing ☐ Shooting ☐ Radiating ☐ Tender ☐ Throbbing
☐ Nauseating ☐ Tingling ☐ Pins/needles ☐ Swelling ☐ Pain after rest

How long this condition has been present: _____ Days _____ Weeks _____ Months _____ Years

Severity of ailment: *(Mark all that apply)*

☐ Getting Better ☐ Stays the Same ☐ Getting Worse ☐ Mild ☐ Moderate ☐ Severe

Timing of onset: *(Mark all that apply)*

☐ Gradual ☐ Sudden ☐ Unknown ☐ Primarily at night ☐ With exercise
☐ After: _____ ☐ Associated with: _____

How did ailment start: *(Mark all that apply)*

☐ No Trauma ☐ Blunt Injury ☐ Cut from Sharp Object ☐ Auto Accident ☐ Trip or Fall
☐ Improper Foot Gear ☐ Sports Related Injury Other _____

What treatments, if any, you have tried: *(Mark all that apply)*

☐ None ☐ Change / Modify Shoe Gear ☐ Physical Therapy ☐ NSAID's ☐ X-Ray
☐ Orthotics / Arch Support ☐ Surgery ☐ Antibiotics ☐ Other_____

Have you ever seen a Podiatrist before? ◯ Yes ◯ No

If yes, please list name _____ Last Visit_____

MEDICAL HISTORY

Primary Care Physician:_____ **Last Visit Date:** _____

Are you now or have you been under the care of a physician during the past two years? ◯ Yes ◯ No

Have you ever had any of the following: Please mark "Yes"

Cardiovascular Problem	☐ Yes	Hepatitis	☐ Yes	Artificial Joint	☐ Yes
Angina	☐ Yes	Kidney Disease	☐ Yes	Degenerative Arthritis	☐ Yes
Heart Attack	☐ Yes	Liver Disease	☐ Yes	Rheumatoid Arthritis	☐ Yes
Heart Disease	☐ Yes	Nose/Throat Problem	☐ Yes	Osteoarthritis	☐ Yes
Congest. Heart Failure	☐ Yes	Hearing Loss	☐ Yes	Gout	☐ Yes
Blood Clots/DVT	☐ Yes	Macular Degeneration	☐ Yes	Back Pain	☐ Yes
High Blood Pressure	☐ Yes	Retinopathy	☐ Yes	Fibromyalgia	☐ Yes
Artificial Heart Valves	☐ Yes	Blindness	☐ Yes	Osteomyelitis	☐ Yes
Heart Murmur	☐ Yes	Bleeding Disorder	☐ Yes	Neurological Disorder	☐ Yes
Skin Disorders	☐ Yes	High Cholesterol	☐ Yes	Neuropathy	☐ Yes
Cellulitis/Skin Infection	☐ Yes	Immunologic Disorder	☐ Yes	Sciatica	☐ Yes
Large Scars	☐ Yes	AIDS/HIV	☐ Yes	Seizure Disorder	☐ Yes
Slow Healing Sores	☐ Yes	Anaphylactic Reaction	☐ Yes	Stroke	☐ Yes
Endocrine Disorders	☐ Yes	Lupus	☐ Yes	Depression	☐ Yes
Diabetes		Tuberculosis	☐ Yes	Chemical Dependency	☐ Yes
Type 1	☐ Yes	Swollen Lymph Nodes	☐ Yes	Respiratory Disorder	☐ Yes
Type 2	☐ Yes	Venereal Disease	☐ Yes	Asthma	☐ Yes
Hypothyroidism	☐ Yes	Rheumatic Fever	☐ Yes	Pulmonary Embolism	☐ Yes
Stomach/Bowel Cond.	☐ Yes	Musculoskeletal Disord.	☐ Yes	Shortness of Breath	☐ Yes
GI Bleed/Ulceration	☐ Yes			Cancer	☐ Yes

Other Medical History_____

HOW DID YOU HEAR ABOUT US?

Dr. Referral (please give doctors name or office) _____

Employee Referral (please give the employee name) _____

Patient Referral (please give the patient name) _____

Other (please specify) _____

- Google Search
- Facebook Ad/Video
- Insurance Referral
- AFAC Website

CONSENT OF RELEASE

In my absence, I authorize AFAC to release all or portions of my or my dependents medical records to those as indicated below. This authorization is in effect until I revoke it in writing.

Name: _____ Name: _____

Name: _____ Name: _____

X _____ _____

Signature of Patient or Parent/Authorized Representative Date

HIPPA NOTICE OF PRIVACY PRACTICES

I acknowledge that, upon request, I was provided access to a copy of the **Notice of Privacy Practices** and that I have read (or had the opportunity to read if I so choose) and understand the notice.

X _____ _____

Signature of Patient or Parent/Authorized Representative Date

_____

Print Name

ASSIGNMENT, RELEASE AND CONSENT

I request that payment of authorized insurance benefits be made either to me or on my behalf to AFAC for any service furnished. I authorize the release of medical information about me needed to determine these benefits or the benefits payable for related services. I understand that my signature requests that payment be made and authorizes the release of medical information necessary to pay the claim.

I understand that I am financially responsible for all charges whether or not paid by insurance. A financial fee of 1.5% per month will be added to all accounts past due. Delinquent accounts over 90 days past due will automatically be sent to a collection agency. Should collections become necessary the responsible party agrees to pay an additional 25% collection fee and all legal fees, with or without suit including attorney fees and court costs. If I have opted out of receiving a final notice for delinquent accounts by text or email below, I understand a letter via certified mail or priority mail will be sent. In sending this letter, a fee of up to $6.00 will be added on top of the additional collection fee mentioned above. In *Medicare assigned cases,* the physician agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and non-covered services.

I understand that I may be billed a $25 no-show fee for appointments that I miss without cancelling or rescheduling at least 24 hours in advance.

I certify that the above information is true and correct to the best of my knowledge. I hereby give my permission to AFAC to administer and perform such procedures and tests as may be deemed necessary in the diagnosis and treatment of my feet/ankles. I authorize the use of photography for documentation and/or educational purposes.

X _____ Date_____

Signature of Patient or Parent/Authorized Representative

We want to stay in touch with you regarding your account and its collection status regarding past due balances. In order for us to contact you regarding all past due accounts and any collection status they may have, you expressly authorize us to contact you by the telephone by sending text messages or e-mails at any number or email you have listed. You acknowledge that such contact could result in charges to you by your telephone carrier. Methods of contact may include the use of pre-recorded/artificial voice messages and/or the use of an automatic telephone dialing system, as applicable. You acknowledge and agree that this authorization shall extend to any billing or collection company or companies which may be assigned.

Yes, I authorize this (initials)_____ No, I do not authorize this (initials)_____