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 _____

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 PO Box

_____
City State Zip

EMERGENCY CONTACT *not in your household:*

Name _____

Relationship _____

Home (_____)_____

Cell (_____)_____

MEDICATIONS

Do you presently take any medications? ☐ Yes ☐ No

If yes, please list all current medications; include prescriptions, over the-counter, herbs & 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 #: _____

INSURANCE

Primary Insurance Company_____

Policy # _____

Subscriber Name _____ **DOB** _____ ___
MM/DD/YYYY

Co-Pay amount (if any) $_____

Secondary Insurance_____

Policy # _____

Subscriber Name _____**DOB**_____

RESPONSIBLE PARTY (for minors)

Name _____DOB_____

Relationship to Insured_____

Phone _____ Cell _____

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** ☐ **SMOKER**

☐ Never Smoked

☐ Former Smoker

How many years? _____

Pick the one that 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 **hospitalization** 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 any that apply)*
☐ Getting Better ☐ Stays the Same ☐ Getting Worse ☐ Mild ☐ Moderate ☐ Severe

Timing of onset: *(Mark any that apply)*
☐ Gradual ☐ Sudden ☐ Unknown ☐ Primarily at night ☐ With exercise
☐ After: _____ ☐ Associated with: _____

How did ailment start: *(Mark any 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" or "No"***

Cardiovascular Problem	☐Yes ☐ No	Kidney Disease	☐Yes ☐ No	Degenerative Arthritis	☐Yes ☐ No
Angina	☐Yes ☐ No	Liver Disease	☐Yes ☐ No	Rheumatoid Arthritis	☐Yes ☐ No
Heart Attack	☐Yes ☐ No	Nose/Throat Problem	☐Yes ☐ No	Osteoarthritis	☐Yes ☐ No
Heart Disease	☐Yes ☐ No	Hearing Loss	☐Yes ☐ No	Gout	☐Yes ☐ No
Congest. Heart Failure	☐Yes ☐ No	Macular Degeneration	☐Yes ☐ No	Back Pain	☐Yes ☐ No
Blood Clots/DVT	☐Yes ☐ No	Retinopathy	☐Yes ☐ No	Fibromyalgia	☐Yes ☐ No
High Blood Pressure	☐Yes ☐ No	Blindness	☐Yes ☐ No	Osteomyelitis	☐Yes ☐ No
Artificial Heart Valves	☐Yes ☐ No	Bleeding Disorder	☐Yes ☐ No	Neurological Disorder	☐Yes ☐ No
Heart Murmur	☐Yes ☐ No	High Cholesterol	☐Yes ☐ No	Neuropathy	☐Yes ☐ No
Skin Disorders	☐Yes ☐ No	Immunologic Disorder	☐Yes ☐ No	Sciatica	☐Yes ☐ No
Cellulitis/Skin Infection	☐Yes ☐ No	AIDS/HIV	☐Yes ☐ No	Seizure Disorder	☐Yes ☐ No
Large Scars	☐Yes ☐ No	Anaphylactic Reaction	☐Yes ☐ No	Stroke	☐Yes ☐ No
Slow Healing Sores	☐Yes ☐ No	Lupus	☐Yes ☐ No	Depression	☐Yes ☐ No
Endocrine Disorders	☐Yes ☐ No	Tuberculosis	☐Yes ☐ No	Chemical Dependency	☐Yes ☐ No
Diabetes	☐Yes ☐ No	Swollen Lymph Nodes	☐Yes ☐ No	Respiratory Disorder	☐Yes ☐ No
Hypothyroidism	☐Yes ☐ No	Venereal Disease	☐Yes ☐ No	Asthma	☐Yes ☐ No
Stomach/Bowel Cond.	☐Yes ☐ No	Rheumatic Fever	☐Yes ☐ No	Pulmonary Embolism	☐Yes ☐ No
GI Bleed/Ulceration	☐Yes ☐ No	Musculoskeletal Disord.	☐Yes ☐ No	Shortness of Breath	☐Yes ☐ No
Hepatitis	☐Yes ☐ No	Artificial Joint	☐Yes ☐ No	Cancer	☐Yes ☐ No

Other Medical History_____

REFERRAL

How did you hear about our office?

☐ Medical Facility / Dr. _____ ☐ Patient _____ ☐ Friend / Family of the doctor

☐ Internet: Site_____ ☐ Insurance Co. ☐ Phone Book

☐ Other _____

CONSENT OF RELEASE

In my absence, I authorize AFAC to release all or portions of my or my dependents, medical record 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

HIPAA NOTICE OF PRIVACY PRACTICES

I acknowledge that 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 chose) and understand the notice.

X_____ _____

Signature of Patient or Parent /Authorized Representative Date

_____

Print Name

ASSIGNMENT, RELEASE & 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 35% collection fee and all legal fees, with or without suit including attorney fees and court costs. 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 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 _____

Patient, Parent, or Guardian Signature