Welcome To
Advanced Foot and Ankle Clinics

Today's Date: ___/___/___

Patient Information

Name: _____
Address: _____
City: _____ State: ____ Zip:_____
Home Phone #: (___) ___-____
Cell#: (___) ___-____
Email: _____
Date of Birth: ___/___/___ Age: ____
Social Security #: _____-_____-_____
Sex: Male __ Female __
Marital Status: S __ M __ W __ D __
Language Spoken:_____
Ethnicity:_____

Your Occupation: _____
Employer: _____
Work #: (___) ___-____

Emergency Contact
Name: _____
Phone #: (___) ___-____
Relationship: _____

Referred By: _____

Social History

Alcohol Usage: Yes _____ No _____
How much:_____ How often:_____

Tobacco Use: Yes _____ No _____
How much:_____ How often:_____
No. of years of tobacco use: _____

Do you use any recreational drugs?

Yes: _____ No: _____
If so, what?_____
How often?_____

Family Physician: _____
Last seen:_____
Are you now, or have you been, under any other doctor's care for any reason the past 2 years?
Yes ___ No ___ If yes, please explain:

Podiatric History

Have you seen a Podiatrist before? Yes ___ No ___
If yes, Dr.'s name:_____
Last Visit:_____

Please indicate which foot/ankle problems you now have or have had in the past.

Ankle Pain.....	Yes ___	No ____
Ankle Sprains.....	Yes ___	No ____
Athlete's Foot.....	Yes ___	No ____
Bunions.....	Yes ___	No ____
Corns.....	Yes ___	No ____
Calluses.....	Yes ___	No ____
Flat Feet.....	Yes ___	No ____
Foot Cramps.....	Yes ___	No ____
Leg Cramps.....	Yes ___	No ____
Hammertoes.....	Yes ___	No ____
Heel Pain.....	Yes ___	No ____
Ingrown Toenail(s).....	Yes ___	No ____
Numbness in feet or legs.....	Yes ___	No ____
Tingling in feet or legs.....	Yes ___	No ____
Plantar Wart(s).....	Yes ___	No ____
Surgery on foot or ankle.....	Yes ___	No ____
Swelling in feet or ankles.....	Yes ___	No ____
Ulcers on foot or ankle.....	Yes ___	No ____
Toenail Removal.....	Yes ___	No ____

What is your chief complaint today?

Shoe Size: _____ Height: _____ Weight: _____

LOVE.YOUR.FEET.

Medical History

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

AIDS/HIV	Yes ___	No ___	Heart Disease	Yes ___	No ___
Alzheimers	Yes ___	No ___	Hepatitis	Yes ___	No ___
Anemia	Yes ___	No ___	High Blood Pressure	Yes ___	No ___
Arthritis	Yes ___	No ___	Hormone Replacement	Yes ___	No ___
Artificial Heart Valves	Yes ___	No ___	Jaundice	Yes ___	No ___
Artificial Joints	Yes ___	No ___	Kidney Problems	Yes ___	No ___
Asthma	Yes ___	No ___	Liver Disease	Yes ___	No ___
Back Problems	Yes ___	No ___	Lung Disease	Yes ___	No ___
Bleeding Disorders	Yes ___	No ___	Neurological Disorder	Yes ___	No ___
Cancer	Yes ___	No ___	Neuropathy	Yes ___	No ___
Chemical Dependency	Yes ___	No ___	Obesity	Yes ___	No ___
Chemotherapy	Yes ___	No ___	Psychiatric Care	Yes ___	No ___
Circulatory Problems	Yes ___	No ___	Respiratory Disease	Yes ___	No ___
COPD	Yes ___	No ___	Rheumatic Fever	Yes ___	No ___
Depression	Yes ___	No ___	Rheumatoid Arthritis	Yes ___	No ___
Diabetes	Yes ___	No ___	Skin Disease	Yes ___	No ___
*Insulin Dependent	Yes ___	No ___	Stomach Ulcers	Yes ___	No ___
*Non-Insulin Dependent	Yes ___	No ___	Stroke	Yes ___	No ___
Epilepsy	Yes ___	No ___	Tuberculosis	Yes ___	No ___
Fibromyalgia	Yes ___	No ___	Thyroid Problems	Yes ___	No ___
GI Disease	Yes ___	No ___	Varicose Veins	Yes ___	No ___
Gout	Yes ___	No ___	Venereal Disease	Yes ___	No ___

Prior surgeries you have had:

_____

_____

Family History

Mother Living: _____ Deceased: _____ Cause of death: _____

Father Living: _____ Deceased: _____ Cause of death: _____

Brother Living: _____ Deceased: _____ Cause of death: _____

Sister Living: _____ Deceased: _____ Cause of death: _____

Medications	Allergies
Include prescriptions, over-the-counter medications & vitamins	Please list all allergies

What pharmacy do you use? _____

Consent

I certify that the above information is true and correct to the best of my knowledge. I give my permission to the doctor to administer and perform such procedures as may be deemed necessary in the diagnosis and/or treatment of my feet and/or ankles.

Patient/Guardian Signature: _____ Date: ___/___/___

General Information:

* Payment is due in full at the time of servic
* If you have insurance, your co-pay or co-insurance will be due at the time of servic
* Insurance benefits and eligibility will be verified prior to services being rendere
* We accept cash, checks, debit, credit cards and Care Credit

(Having insurance is not a guarantee of payment. If your insurance gives our staff incorrec benefits and eligibility for a service, it is still the responsibility of the patient to pay for any and a services/treatment that were performed on your behalf)

Proof of Insurance:

* All patients must complete our patient information form before being seen by the docto

We must obtain a copy of your driver's license/ID and insurance card. If you fail to provide u with the correct insurance information, you may be responsible for the balance of the claim. I required, obtaining the proper referral from your primary care physician is your responsibilit

Patients with Insurance:

* As a courtesy, we will submit a claim for your visit to your insurance compar
* If the insurance company deems there is a problem with the claim, we will work with th representative to try and fix the problem and resubmit the claim.
* If your insurance denies a service you are responsible for the amount due for that clai
* Any and all denials by your insurance will become patient responsibility to pa

Co-payments, Deductibles and Co-Insurance:

* The co-pay or co-insurance amount is due at time of servic
* If you have not yet met your yearly deductible, the full fee(s) for services rendered will be due a the time of service
* Even with insurance, some services may be deemed "non covered" and you will be responsibl for those fees

Medicare Insurance:

* After your yearly deductible is met, we will accept assignment of benefits as set forth in Medicar part B plans
* As set forth in your Medicare handbook, the co-insurance amount is 20% of Medicare' "allowable" will be collected at the time of service if you do not have a supplemental insurance if the supplemental insurance does not cover the service(s) rendere
* Medicare does not cover all services. Any non-covered service/treatment must be paid in full a the time of service. Our staff strives very hard to keep patients informed of any non-covered services and will alert you prior to the service if possible

Non-Covered Services:

* You are responsible for any non-covered services you choose to receive. Please be aware that some and perhaps all of the services you receive may not be covered by your insurance. An non-covered service will not be billed to your insurance. Payment will be due at time of service full.

Patient/Guardian Signature: _____ Date: ___/___/___
Relationship to patient: _____

Office Visits:

* New patients need to arrive 30 minutes prior to the scheduled appointment time. If yc
cannot arrive early, your appointment with the doctor may be delayed
* Late arrivals of 10 minutes or more may be asked to reschedul
* All appointment cancellations need to be made 24 hours prior to the scheduled appointme
* If you miss/no show for your appointment 2 times or more you may not be able to get anothe
appointment.

Prescription Refills:

* It may take up to 24 hours for a prescription refill reques
* If you call on a Friday for a prescription refill request please note that it will be handled the ne
business day which would be Monday
* We will perform a urine test and/or a mouth swab for patients requesting pain prescription refi
* We will not replace lost or stolen prescription

Medical Record Requests:

* All requests for medical records require a "Medical Record Release" form to be filled out an
signed by the patient or guardian requesting the information
* It may take up to 72 hours from the time we receive the medical release form in order to g
the records ready for you to pick up.
* It will take 5 business days to complete any paperwork requests from places of employment
disability paperwork, attorney, etc. There is a $15 fee for all paperwork that needs to be filled out.

Patient/Guardian Signature: _____ Date: ___/___/___
Relationship to Patient: _____

Advanced Foot and Ankle Clinics

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(479)271-5353

Notice of Privacy Practices Acknowledgement

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPPA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

1) Conduct, plan and direct my treatment and follow up among multiple healthcare providers who may be involved in my treatment directly or indirectly
2) Obtain payment from third party payers
3) Conduct normal healthcare operations such as quality assessments and physician certifications

I have been given the right to review the Notice of Privacy Practices, found in the waiting room, prior to signing this acknowledgement.
I understand that I may ask for a copy of these Privacy Practices.
I understand that Advanced Foot and Ankle Clinics reserves the right to change these policies at any time and I may contact the office for an updated copy of it at any time.
I understand that I may request, in writing, that Advanced Foot and Ankle Clinics restrict how my private information is used or disclosed to carry out treatment, payment, or healthcare options. I also understand that if I request my information be withheld from an insurance company, and this witholding affects payment from that company, I will be responsible for payment in full to Advanced Foot and Ankle Clinics.

Patient/Guardian Signature: _____
Printed Name of Signature: _____
Date: ___/___/___

To maintain my privacy practice, I authorize Advanced Foot and Ankle Clinics to release my personal history information in the following manner:
___ A detailed message may be left on my personal number. PHONE NUMBER: _____
___ A message with a call back number only
___ A detailed message may be left at my work. WORK NUMBER: _____
___ A message with a call back number only to my work.

Written Communication:
___ It is okay to mail to my home address
___ It is okay to mail to my work
___ It is okay to fax information to me at the following fax number: _____

Other than myself, I only allow _____ (specific person) to receive the following information:
___ Appointment information
___ Billing information
___ Prescription or medication information

Patient/Guardian Name: _____ Date: ___/___/__