

Foot & Ankle Specialists, P.C.

Dr. Scott E. Hughes * Dr. Greg P. Vogt * Dr. Christine I. Tumele

PATIENT INFORMATION

Patient Name _____ Date _____

Address _____ City _____ State ____ Zip _____

Birth date _____ Age _____ Sex _____

Email to receive correspondence _____

SS# (required) _____

Home Phone _____ Cell _____ Work _____

Do you wish to be contacted by phone (please circle) Y N

Occupation/Employer _____

Emergency Contact _____

Relationship _____ Phone _____

Your Preferred Pharmacy _____ **Address/City** _____

Who referred you to our office: _____

INSURANCE INFORMATION

Person responsible for payment _____

Billing Address (if different) _____ City _____ State ____ Zip _____

Birth date _____ SS# _____

Primary Insurance _____

Secondary Insurance _____

Other Insurance _____

****Please make sure that we have made a copy of your insurance card(s)****

****We are required to request this information by the Federal Government, but you are not required to answer****

Race: Native American Asian African American Caucasian

Ethnicity: Hispanic/Latino Non-Hispanic/Latino

Is your preferred language something other than English? (If yes, please specify) _____

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PATIENT INTAKE FORM

Patient Name _____ Date _____

Please fill out this form to the best of your knowledge. We can also assist you. This gives our doctors important information about your health. We are interested to learn about you and this helps us to help you. Thank You.

REVIEW OF SYSTEMS: Please check if you are experiencing any of the following:

Constitutional:

- Change in thirst or appetite
- Chills
- Fatigue
- Fever
- Weight Change

Genitourinary:

- Frequent UTI's

Musculoskeletal:

- Uses an Assistive Device
- Back Pain
- Feet & Ankle Swelling
- Joint Pain
- Paralysis

Psychiatric:

- Chemical Dependency
- Emotional Problems
- Forgetfulness

Eyes:

- Eye or vision Problems

Cardiovascular:

- Chest Pain
- Cold Feet
- Cold Intolerance
- Heart Palpitations
- Racing Heart
- Slow Heartbeat

Dermatologic:

- Rash
- Skin Sores
- Endocrine:
 Elevated liver enzymes

Hematologic:

- Bleeding tendency
- Cuts take long to heal
- Swollen Lymph Nodes

Ear/Nose/Throat/Neck:

- Difficulty hearing

Respiratory:

- Breathing Difficulty
- Cough
- Shortness of breath

Gastro:

- Heartburn
- Nausea or Vomiting

Neurologic:

- Numbness
- Tingling
- Weakness

LIST ALL SURGERIES, THE DATE AND THE DOCTOR: Please write on back if more room is needed.

PAST MEDICAL HISTORY: Please check the items if you've EVER been diagnosed as having and CIRCLE the associated disease that follows. Please write in any diseases not mentioned below that you suffer from.

- Abuse of:** Alcohol, Narcotics, Cocaine, Heroin, Prescriptions
- Anemia:** Folate, Iron deficiency, Sickle Cell, B12, Not sure
- Angina:** Stable, Unstable, Not sure
- Anxiety disorder:** PTSD, OCD, Panic, Manic Depressive
- Arthritis:** DJD, Gout, Osteoarthritis, Joint Replacement Surgeries (list above in surgery section)
- Asthma:** Mild, Moderate, Severe
- Autoimmune Arthritis:** Lupus, MCTD, Scleroderma, Rheumatoid Arthritis, JRA, Psoriatic Arthritis
- Back Injury:** Fracture, Disc Herniation, Sprain, Previous Back Surgery (list above in surgery section)
- Back Pain:** Disc Disease, Sciatica, Arthritis, Previous Back Surgery (list above in surgery section)
- Bleeding Disorder:** Platelet Dysfunction, Blood Thinner Medication, Bruise Easily
- Bowel Problems:** Inflammatory Bowel Disease, Chron's, IBS, Ulcerative Colitis, Colostomy
- Broken Bone:** Hand, Foot, Ankle, Leg, Arm, Hip, Shoulder, Neck, Back
- Cancer:** Brain, Thyroid, Leukemia, Metastasis, Liver, Kidney, Lung

- Cancerous Tumors:** Breast, Cervical, Ovarian, Uterine, Prostate, Melanoma, Colon, Skin
- Cardiac Arrhythmia:** Atrial Fibrillation, Slow or Fast Heartbeat, Pacemaker, Tachycardia, PVC's
- Circulation Problems:** in hands, in legs, in feet
- Dementia:** Alzheimer's, Alcoholic, Senile, Memory Loss
- Diabetes:** Pregnancy Onset, Juvenile, Adult Onset, Diet Controlled, Controlled, Poor Control
- Ear Problems:** Infection, Hearing Loss, Ringing
- Eye Problems:** Glaucoma, Macular Degeneration, Retinopathy, Blindness
- Headaches:** Tension, Stress, Migraine
- Heart Condition:** Mitral Valve Prolapse, Valve Replacement, Heart Attack, Congestive Heart Failure, Murmur, Coronary Artery Disease
- Hepatitis:** A, B, C, Not Sure
- HIV or Aids**
- High Blood Pressure:** Controlled, Uncontrolled
- Kidney Disease:** Dialysis, Failure, Insufficiency, Infections, Arterial Stenosis
- Liver Disease:** Cirrhosis, Fatty, Ascites
- Menopause**
- Neurologic Disease:** Multiple Sclerosis, Polio, Parkinson's Disease, Neuropathy, RSD
- Venous Blood Clot or Phlebitis:** Superficial, Deep, Arm, Leg, Lung
- Pinched Nerves:** Sciatica Right Leg, Sciatica Left Leg, Carpal Tunnel Syndrome
- Psychiatric Care:** Depression, ADD, Bipolar, Delusional, Stress
- Rash:** Eczema, Psoriasis
- Reynaud's Syndrome**
- Respiratory Condition:** History of Smoking, COPD, Bronchitis
- Rheumatic Fever**
- Seizure Disorder:** Epilepsy, Grand Mal, Focal, Partial
- Sinus Conditions:** Seasonal Allergies, Infection, Sinusitis
- Stomach Problems:** GERD, Diverticulitis, Constipation, Diarrhea, Polyps, Ulcers
- Stroke:** TIA, CVA
- Tuberculosis or TB:** Active Infection, Carrier, Treated, Positive Test Without Infection
- Thyroid Disorder:** Hyperthyroidism, Hypothyroidism
- Ulcers:** Legs, Feet
- Other Diseases:** _____

FAMILY HISTORY:

- Mother: Heart Problems Cancer Diabetes Arthritis Other: _____
- Father: Heart Problems Cancer Diabetes Arthritis Other: _____
- Sisters: Heart Problems Cancer Diabetes Arthritis Other: _____
- Brothers: Heart Problems Cancer Diabetes Arthritis Other: _____
- Children: Heart Problems Cancer Diabetes Arthritis Other: _____

SOCIAL HISTORY: Circle the proper answers for you

ALCOHOL USE:

I drink alcohol: 0 - 1 time weekly / 3 times a week / Daily / Special Occasions / I am a recovering Alcoholic

DIET:

I eat a: Regular Diet / Fast Food / Low Fat / Low Salt / Low Sugar / Weight Loss Diet

EMPLOYMENT:

My Employment requires: Prolonged Standing / Prolonged Walking / Prolonged Sitting / Other _____

EXERCISE:

I exercise: 1-3 times per week / more than 4 times a week, by _____

__ Sports I participate in : _____

DRUG HISTORY:

I use these illegal drugs: None / Cocaine / Heroin / Narcotics / Other _____

SMOKING HISTORY:

__ I do not smoke

__ I smoke __ packs of cigarettes every ____ day(s) for _____ years.

__ I quit smoking, How long ago _____. I used to smoke _____ packs per day for ____ years.

MEDICATIONS: Please LIST ALL NON-PRESCRIPTION AND PRESCRIPTION MEDICATIONS, vitamins, and herbs you take (include injections at home or from a doctor's office). We can make a photocopy of your medications list.

ALLERGIES: Please list Allergies and types of Allergic Reactions.

__ Adhesive tape	__ Demerol	__ Novocain	Other: _____
__ Anticoagulants	__ Eggs	__ Peanuts	_____
__ Aspirin	__ Iodine	__ Penicillin	_____
__ Cipro	__ IVP Dye	__ Seafood	_____
__ Codeine	__ Latex	__ Sulfa	_____

Are you pregnant? Yes / No / Not Sure Expected due date: _____

Name of Family Physician _____

Phone Number of Physician _____

Most Recent Date of Physical Exam _____

Are you currently under the care of this doctor? Yes / No

If yes, please state the reason _____

Authorization for Treatment

I certify that the information I have provided concerning my health and medical history is complete, true and correct to the best of my knowledge. I understand that any omissions may jeopardize my health and I cannot hold Foot & Ankle Specialists, P.C. responsible for any misinformation that I supplied. I give permission to the doctors of Foot & Ankle Specialists, P.C. to administer and perform services and/or procedures as may be deemed necessary in the diagnosis and treatment of my feet, ankles, or hands.

Signature of Patient _____ Date _____

FAS Initials _____ Date _____

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OFFICE POLICY AGREEMENT

INITIAL REGISTRATION AND UPDATES

Please fill out the registration forms as completely as possible. Be sure to read and sign the “consent for treatment” section. If there is ever a change in your name, health insurance, address or phone number, please notify our front desk. Your Medical history will be reviewed and updated as needed at each appointment.

INSURANCE

Present your insurance card to our receptionist at your first appointment. We must have complete and accurate information to file your claim. Benefits will be verified through your insurance carrier prior to being seen by the doctor. Please be aware that you have final responsibility for payment of services rendered. Any amount not covered or not paid by your insurer will be billed to you directly.

PAYMENT AT TIME OF SERVICE

Payment for all deductibles, copayments, and non-covered services is due at the time of treatment, unless previous arrangements have been made with our billing department. For your convenience, we accept cash, personal checks, Mastercard, Visa, and Discover. There is a \$30 fee for checks returned by your bank.

COLLECTION POLICY

Statements will be sent monthly for any balance due on your account. If no extended payment arrangements have been made, we expect full payment for services rendered within 15 days. You can mail your payment, call and pay with a credit card over the phone, or pay online from your patient portal.

If an account balance has not been paid in full within 90 days, no additional appointments will be scheduled until the balance is paid. Accounts may then be referred to a collection agency. You will be responsible for any collection and/or court costs incurred during the collection process.

The responsibility for payment of services rendered to dependent children rests with the parent who seeks treatment for the child. Any court ordered responsibility judgement must be handled between the individuals involved, without the inclusion of our office.

APPOINTMENT POLICY

As a courtesy, our office will attempt to contact you the day before your scheduled appointment. However, the responsibility for keeping appointments is yours. If it is necessary to reschedule an appointment, please give us as much notice as is possible so we can schedule another patient during that time.

It is our hope that the above office policies will allow us to provide quality care to our valued patients. If you have any questions or need clarification of any of these policies, please do not hesitate to ask.

My signature below indicated that I have read the statements above, understand, and agree to comply with this policy.

Patient Signature

Date

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Acceptance of Financial Responsibility **Assignment of Benefits** **Authorization to Release Information**

Patient Name _____ Date _____

- I, the undersigned certify that I (or my dependant) have insurance coverage with:

- I assign directly to Foot & Ankle Specialists, P.C. all Medicare / other insurance benefits, if any, otherwise payable to me for services rendered.
- I understand that ultimately, I am financially responsible for all charges whether or not they are paid by insurance.
- I hereby authorize Foot and Ankle Specialists, P.C. to release all information necessary to secure the payment of benefits.
- I authorize the use of this signature or its copy on all Medicare/ other insurance submissions.
- Information to process a claim on my behalf may be released to my insurance company.

Signature _____ Date _____

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Acknowledgement of Receipt of Foot & Ankle Specialists, P.C.'s Notice of Privacy Practices

I acknowledge that I will be provided a copy of the Notice of Privacy Practices if I desire, that I have read (or had the opportunity to read) and understood the Notice.

Patient Name (Please Print)

Date

Authorization to Use or Disclose Protected Health Information

I authorize Foot & Ankle Specialists, P.C. to discuss and/or disclose my Private Health Information (PHI) to the following individual's as described below:

____ Spouse _____
____ Adult Child(ren) _____
____ Parent(s) _____
____ Other _____

Expiration: This authorization will stay in effect unless I set an expiration date, or it is otherwise revoked.

Signature

Date

Witness