ADVANCED FOOT & ANKLE CENTER - PATIENT INFORMATION FORM

(PLEASE PRINT)

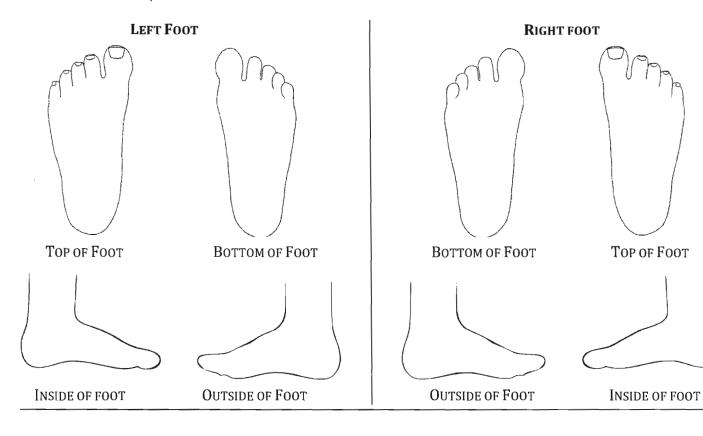
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PRIMARY CARE DOCTOR:	Wно	REFERRED YOU TO	o us?
			PHONE #: ()
			SHARE YOUR MEDICAL INFORMATION?
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IF YOU HAVE DIABETES PLEASE ANSWER THE FOLLOWING QUESTIONS: HOW LONG HAVE YOU HAD DIABETES? DO YOU HAVE BURNING, TINGLING OR NUMBNE! HOW MANY TIMES A DAY DO YOU CHECK YOUR BLOOD SUGARS? WHAT WAS YOUR MOST RECENT BLOOD SUGAR LEVEL? MOST RECENT A1C? SOCIAL HISTORY MARTIAL STATUS: SINGLE MARRIED PARTNERED SEPARATED DIVORCED W USE OF ALCOHOL: NEVER NO LONGER USE HISTORY OF ALCOHOL ABUSE CURRENT USE - TYPE MARRIED CASSIONAL MODERATE DAILY USE OF TOBACCO: NEVER QUIT - HOW LONG AGO? SMOKE PACKS/DAY FOR USE OF RECREATIONAL DRUGS: NEVER QUIT - HOW LONG AGO? TYPE CURRENT USE - TYPE RARE COCCASIONAL MODERATE DAILY WHO WHAT WAS YOUR ON YOUR FEET AT WORK? 10% 25% 50% 75% 100% DO OTHERS DEPEND UPON YOU FOR THEIR CARE? CHILDREN-AGE(S) PET(S)—WHAT KIND? ELDERLY OR DISABLED FAMILY MEMBER OTHER EXERCISE: NEVER RARE COCCASIONAL WEEKLY SEVERAL TIMES A WEEK DAILY TYPES OF EXERCISE: FAMILY HISTORY DO YOU HAVE A FAMILY HISTORY OF: DIABETES CANCER HEART DISEASE RHEUMATOID AT TYPES OF EXERCISE. HAVE YOU EVER HAD ANY OF THE FOLLOWING? ALERGIES: NONE KNOWN MEDICATIONS ANESTHESIA FOODS ARTHRITS YN N HEART ATTACK YN N NEUROPATHY ABBUILA HISTORY ANEBULA HY N HEART ATTACK YN N PREUMANDIA ASHMA YN HEART ATTACK YN N PREUMONIA ASHMA YN HEART ATTACK YN N RHEWATTIC FEVER BLADDER INFECTIONS YN HEART TITLES YN N RHEWATTIC FEVER BLADDER INFECTIONS YN HIGH BLOOD PRESSURE YN SLEEPE APNEA BLOOD TRANSPUSION YN HIGH BLOOD PRESSURE YN SLEEPE APNEA BLOOD TRANSPUSION YN HIGH BLOOD PRESSURE YN SLEEPE APNEA BROOCHTITS/EMPHYSEMA YN N LEG CRAMPS YN N SLEEP APNEA BROOCHTITS/EMPHYSEMA YN N LEG CRAMPS YN N SLEEPE APNEA			DATE				Sur	Түре оғ — ——	DATE	· ·	EKIE	LEASE LIST ALL PRIOR SURG	
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CURRENT PROBLEM

MILLAR CDECLEIC DRODLEM DRINGS VOLUDO OUR OFFICE HORAN	
WHAT SPECIFIC PROBLEM BRINGS YOU TO OUR OFFICE TODAY?	

WHERE IS THE PAIN/PROBLEM LOCATED? PLEASE MARK ON THE PICTURES BELOW.



HOW LONG AGO DID THIS PROBLEM FIRST START? _____ DAYS / WEEKS / MONTHS / YEARS

DID YOUR PAIN OR PROBLEM: BEGIN ALL OF A SUDDEN GRADUALLY DEVELOP OVER TIME	
How would you describe your pain? No pain Sharp Dull Aching Burning Radiating Itching Stabbing Other	-
How would you rate your pain on a scale from 0 to 10? (please circle) (no pain) 0 1 2 3 4 5 6 7 8 9 10 (worst pain possible)	
SINCE THE TIME YOUR PAIN OR PROBLEM BEGAN, HAS IT: STAYED THE SAME BECOME WORSE IMPROVED	
WHAT MAKES YOUR PAIN OR PROBLEM FEEL WORSE? WALKING STANDING DAILY ACTIVITIES RESTING Dress shoes High heels Flat shoes Any closed toe shoe Running Other	
What makes your pain or problem feel better?	
What treatments have you had for this problem?	
How has this problem affected your lifestyle or ability to work?	
Was this problem caused by an injury? Yes (describe) No	١
IF YES, WAS IT A WORK-RELATED INJURY? YES NO	
ACKNOWLEDGMENT: "I HAVE REVIEWED THE ABOVE INFORMATION AND VERIFY THAT IT IS CORRECT. I UNDERSTAND A MEDICARE CHARGES ARE DUE AND PAYABLE IN FULL AT THE TIME OF SERVICES. I AUTHORIZE MEDICARE AND ALL OTHER IN COMPANIES TO PAY BENEFITS DIRECTLY TO THE PHYSICIAN. I ALSO AUTHORIZE ANY HOLDER OF MEDICAL INFORMATION ABOUT THE CENTERS FOR MEDICARE AND MEDICAID SERVICES AND ITS AGENTS ANY INFORMATION NEEDED TO DETERMINE BENEFITS OR THE BENEFITS PAYABLE FOR RELATED SERVICES. I ALSO AUTHORIZE THE PRACTICE TO OBTAIN MY MEDICATION HIS	ISURANCE UT ME TO INE THESE
SIGNATURE DATE	

Patient Financial Policy

Your understanding of our financial policies is an essential element of your care and treatment. If you have any questions, please discuss them with our front office staff or supervisor.

- · As our patient, you are responsible for all authorizations/referrals needed to seek treatment in this office.
- · Unless other arrangements have been made in advance by you, or your health insurance carrier, payment for office services are due at the time of service. We will accept VISA, MasterCard, Discover, cash or check.
- · Your insurance policy is a contract between you and your insurance company. As a courtesy, we will file your insurance claim for you if you assign the benefits to the doctor. In other words, you agree to have your insurance company pay the doctor directly. If your insurance company does not pay the practice within a reasonable period, we will have to look to you for payment.
- · We have made prior arrangements with certain insurers and other health plans to accept an assignment of benefits. We will bill those plans with which we have an agreement and will only require you to pay the co-pay/co-insurance/deductible at the time of service.
- · If you have insurance coverage with a plan with which we do not have a prior agreement, we will prepare and send the claim for you on an unassigned basis. This means your insurer will send the payment directly to you. Therefore, all charges for your care and treatment are due at the time of service.
- All health plans are not the same and do not cover the same services. In the event your health plan determines a service to be "not covered," or you do not have an authorization, you will be responsible for the complete charge. We will attempt to verify benefits for some specialized services or referrals; however, you remain responsible for charges to any service rendered. Patients are encouraged to contact their plans for clarification of benefits prior to services rendered.
- · You must inform the office of all-insurance changes and authorization/referral requirements. In the event the office is not informed, you will be responsible for any charges denied.
- · For most services provided in the hospital, we will bill your health plan. Any balance due is your responsibility.
- There are certain elective surgical procedures for which we require pre-payment. You will be informed in advance if your procedure is one of those. In that event, payment will be due one week prior to the surgery.
- Past due accounts are subject to collection proceedings. All costs incurred including, but not limited to, collection fees, attorney fees and court fees shall be your responsibility in addition to the balance due this office.
- · There is a service fee of \$25.00 for all returned checks. Your insurance company does not cover this fee.

Signature of Patient/Responsible Party:		
Printed Name of Patient/Responsible Party	Date:	
Witness Signature:	Date:	
Printed Name of Witness:		
Patient initials to indicate copy received.		