Advanced Foot And Ankle Specialists

Name: _____ **Date of birth**:____/____/____ **Age:** _____
First Middle Last

Address: _____
Street City State ZIP

Home Phone: ( ) _____ **Cell Phone**: ( )_____

Work phone: ( ) _____ Ext.:_____

E-mail address: _____**Social Security #:** _____ **Sex**: Male Female

Marital Status: [ ] Single [ ] Married [ ] Separated [ ] Divorced [ ] Widowed

Primary Care Doctor: _____ **Phone #**: _____

Address: _____

Pharmacy:_____**Location:** _____ **Pharmacy phone #** _____

Whom may we thank for referring you to our office? _____
Other referring source: [ ] Internet [ ] Newspaper [ ] Magazine Ad [ ] Insurance [ ] Family/Friend [ ] Phone book [ ] Other: _____

What brings you to the office today? _____
How long have you had this problem? _____

PATIENT EMPLOYER INFORMATION

Patient's employer name: _____

Address: _____
Street City State ZIP

Patient's occupation: _____ Contact person (at work): _____

Contact phone: ( ) _____ Fax: ( ) _____
1) If today's visit is due to an injury at work please circle: YES NO
2) Have you notified your personnel department? YES NO
3) Please give brief description of injury:_____
_____

POLICY HOLDER EMPLOYER INFORMATION

Policy holder name: _____

Address:_____
Street City State Zip

Policyholder date of birth: _____ Social Security #: _____ Sex: M F

Policy holder employer name: _____

Address:_____
Street City State Zip

INSURANCE INFORMATION

Primary insurance company name: _____ ID/Member #: _____

Group name: _____Group #: _____ Effective date: _____ COPAY: $_____

Patient's relationship to policyholder: _____ Policyholder name: _____

Secondary insurance company name: _____ ID/Member #: _____

Group name: _____ Group #: _____Effective date:_____

Patient's relationship to policyholder: _____ Policyholder name:_____ Date of Birth: _____

EMERGENCY CONTACT INFORMATION

Name: _____ Relationship: _____

Address: _____
Street City State ZIP
Home phone: ( ) _____ Work phone: ( ) _____ Ext.:_____

MEDICAL HISTORY (PLEASE CIRCLE WHAT APPLIES)

Diabetes	Gout	Heart disease	High blood pressure
Stroke or heart attack	Stomach ulcer/reflux	Thyroid disease	Liver disease
Kidney or bladder	Bleeding disorders	Anemia/blood	Asthma/bronchitis
Rheumatic fever	Accident/injuries	Immune disease	Cancer
Epilepsy/seizures	Depression or anxiety	Vascular/circulatory disease	Arthritis
Foot problems	**[ ] I HAVE NONE OF THESE**	**OTHER:_____**	

HEIGHT: _____ WEIGHT:_____ SHOE SIZE:_____

MEDICATIONS (please include dosage of each)

[ ] I AM TAKING NO MEDICATIONS

1.) _____ 5.) _____
2.) _____ 6.) _____
3.) _____ 7.) _____
4.) _____ 8.) _____

ALLERGIES: (Penicillin, Novocain, tape, foods, etc)

[ ] I HAVE NO KNOWN ALLERGIES

1.) _____ 3.) _____
2.) _____ 4.) _____

SURGERIES and HOSPITALIZATIONS: (describe procedure, year and any complications)

1.) _____
2.) _____
3.) _____
4.) _____

SOCIAL HISTORY

Tobacco: If yes, how much? _____Alcohol: If yes, how much? _____

FAMILY HISTORY (diabetes, heart disease, gout, cancer, foot problems or other): _____

_____
_____

EXPLANATION OF PAYMENT POLICY AND INSURANCE FILING PROCEDURES

I hereby authorize Advanced Foot and Ankle Specialists, to release medical information and necessary data pertinent to the filing of insurance papers in the interest of the patient named above and the facility. I authorize my insurance carriers to pay benefits directly to Advanced Foot and Ankle Specialists on any unpaid services filed on my behalf by Advanced Foot and Ankle Specialists.

I understand that I am responsible for payment to Advanced Foot and Ankle Specialists for charges for the above patient, regardless of my insurance coverage. I also understand that Advanced Foot and Ankle Specialists is not ultimately responsible for collecting my insurance or negotiating settlements of claims.

I hereby give Advanced Foot and Ankle Specialists permission to diagnose and administer treatment for my foot condition and authorize any release of information obtained in the course of my treatment.

[ ] A message may be left on my answering machine
[ ] Test results may be discussed with my family
Test results **may/may not** be left on my answering machine

Patient's signature: _____ Date: _____/_____/_____

Signature of parent/guardian: _____Date: _____/_____/_____