Foundation Foot & Ankle, LLC

PATIENT INTAKE FORM – PLEASE USE BLACK INK

Date _____

Patient's Name _____ _ Age_____ Patient's Birthdate _____
First M.I. Last

Soc Sec # _____

Spouse's Name_____ Marital Status- *circle one*: S M D W
First M.I. Last

Responsible Party/Parent *(if child)*_____
First M.I. Last Relationship

Patient's Address_____
Number & Street (If PO Box, include street address) City State Zip code

Home Phone (_____)_____ Mobile phone (____)_____ E-Mail Address_____

Patient's Employer (if child, father's)_____ Employer's Phone (____)_____

Patient's Insurance (if child, father's)_____ Soc Sec #_____ Birthdate_____

Spouse's Employer (if child, mother's)_____ Employer's Phone (____)_____

Spouse's Insurance (if child, mother's)_____ Soc Sec #_____ Birthdate_____

Emergency Contact or Next of Kin / Phone / Relationship _____
This should be someone outside of your home, if possible

Family Dr. _____ Y_____ N_____
First M.I. Last City State Did he / she refer you?

Referred By _____
First M.I. Last City State Relationship

Preferred Pharmacy Name / Location _____

How did you find out about us? ____Another patient _____Phonebook ____Sign ____Newspaper _____Internet: **www.foundation-foot-ankle.com**

FAMILY MEDICAL HISTORY:

Has anyone in your immediate family ever had: Diabetes; Heart disease; High blood pressure; Stroke; Bleeding disorder; Cancer; Depression
_____NO _____YES, please list details below

Relationship: **Disease / Ailment:**

Father_____

Mother _____

Siblings_____

PERSONAL HISTORY:

Height____'____" Weight_____lbs Shoe size_____ Do you Smoke? ____Yes ____No

RACE: ____White / Non-Hispanic ____African American ____Hispanic ____Other:_____

LANGUAGE: ____English ____Spanish _____Other:_____ Females: are you pregnant at this time? ____Yes ____No

Office Use Only:

Affirmation and Consent for Medical Treatment

I certify that the information that I have provided is true and correct to the best of my knowledge. I, the patient, or the patient's legal representative, hereby authorize and give my consent to Foundation Foot & Ankle, LLC, to administer and perform such procedures as may be deemed medically necessary in the diagnosis and/or treatment of my feet and/or ankles.

Consent to Release Medical Records for Insurance or Third Party Reimbursement

I, the patient, or the patient's legal representative, hereby authorize and give my consent to Foundation Foot & Ankle, LLC, to release medical records prepared in the course of my treatment to any entity which provides financial assistance for the patient's healthcare including, but not limited to, insurance companies, self-insured employers or public welfare agencies, and/or to maintain continuity of care.

I, the patient, or the patient's legal representative, understand that by signing this form, records of a confidential nature, such as those for HIV testing, AIDS or AIDS-related conditions, psychiatric problems or substance abuse, will be released to the entities providing financial assistance for my health care.

I, the patient, or the patient's legal representative, hereby authorize and give my consent to Foundation Foot & Ankle, LLC, to release medical records prepared in the course of my treatment to any entity, including but not limited to, referring physicians, hospitals, or other healthcare providers, which may be of assistance in the opinion of this office, in providing for the treatment of the patient.

I, the patient, or the patient's legal representative, hereby authorize the direct payment of insurance claims to Foundation Foot & Ankle, LLC.

The signature furnished below shall suffice for all insurance forms on a continuing basis.

Acknowledgment of Notice of Privacy Practices

I acknowledge that I have been given the opportunity to review a statement of the Foundation Foot & Ankle, LLC Notice of Privacy Practices.

Acknowledgment of Financial Policy

I acknowledge that I have received and read a statement of the Foundation Foot & Ankle, LLC Financial Policy.

X_____

Signature of Patient / Legal Representative Relationship Date

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For Office Use Only

I certify that I have received my previous answers on the Patient Registration, Medical History, Review of Systems, and Medication Forms, and that everything is currently correct or that I have updated any incorrect information.

_____

Signature of Patient / Legal Representative Relationship Date

_____

Signature of Patient / Legal Representative Relationship Date