# Foundation Foot & Ankle, LLC

# PATIENT INTAKE FORM – PLEASE USE BLACK INK

Date						
Patient's Name				Age	Patient's Birthdat	e
First	М.І.	Last			Soc Sec #	
Spouse's Name					Marital Status	- circle one: S M D W
First	M.I.	Last				
Responsible Party/Parent (if chi	ild) First	M.I.	Last		Relationship	
Patient's Address						
	Street (If PO Box, includ	,	•		State	Zip code
Home Phone ()						
Patient's Employer (if child, fath	er's)				Employer's Phone (_	)
Patient's Insurance (if child, fatl	her's)			Soc Sec #_		Birthdate
Spouse's Employer (if child, mo	other's)				Employer's Phone (_	)
Spouse's Insurance (if child, mo	other's)			Soc Sec #_		Birthdate
Emergency Name / Phone / Rel		d be semes as as	toido of vour homo	if necesible		
	THIS SHOUL	d be someone out	iside di your nome	e, ii possibie		
5 " B						V N
Family Dr	M.I.	Last	C	ity	State	Y N Did he / she refer you?
Referred By						
First	M.I.	Last	C	ity	State	Relationship
Preferred Pharmacy Name / Loc	cation					
How did you find out about us?	Another patient	Phonebook	SignN	lewspaper _	Internet: www.fo	undation-foot-ankle.com
FAMILY MEDICAL HISTORY:						
Has anyone in your immediate f	amily ever had. Diah	atas: Haart disaas	se: High blood pr	essure: Strol	ke; Bleeding disorder;	Cancer: Depression
That anyone in your mimediate i		_NOYES,			te, Bleeding disorder,	Cancer, Depression
Relationship:	Disease / Ailment:					
Father						
MotherSiblings						
PERSONAL HISTORY:						
Height' Weight	lbs Shoe size	S	mokepk/day	,AI	coholoz/day	Caffeineper day
RACE:White / Non-Hispa	nicAfrican Amer	icanHispar	nicOther:_			
LANGUAGE:English	_SpanishOther:				Are you a Veter	an?YesNo
Previous Hospitalizations / Surgeries				emales: Are	·	ne?YesNo
ALLERGIES: Please check the						
NO KNOWN ALLI Adhesive tape		Cortisone Demerol		anesthesia		e. lotions/creams
Aspirin Codeine		odine dye odine, topical	Nova Penid		Other:	
Describe reactions:		, 1				

Patient Intake Form 5/2014

#### **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	
For Office Use Only			
I certify that I have received my previous answers on the Forms, and that everything is currently correct or that I have		y, Review of Systems, and Medication	
Signature of Patient / Legal Representative	Relationship	Date	
Signature of Patient / Legal Representative	Relationship	Date	