FOOT & ANKLE SURGICAL GROUP

PATIENT INFORMATION

First Name	MI	Last Name	
Preferred Name	Date of Birth	Sex	SSN
Address	City	State	Zip
Cell Phone	Home Phone	Email	

REFERRAL

How did you hear about us? □ Insurance □ Online □ Other Patient □ Physician

PRIMARY CARE PHYSICIAN

Name/Practice Name	Phone

EMERGENCY CONTACT

Name	Phone	Relationship

PRIMARY INSURANCE

Primary Insurance	Member ID	Group ID	
Policy Holder	DOB	SSN	Relationship

SECONDARY INSURANCE

Secondary Insurance	Member ID	Group ID	
Policy Holder	DOB	SSN	Relationship

REVIEW OF SYSTEMS (CHECK ALL THAT APPLY)

Cardiovascular □ chest pain □ cold feet □ leg cramps □ leg swelling

Constitutional □ chills □ fatigue □ fever

Endocrine □ heat/cold intolerance

Gastrointestinal □ diarrhea □ nausea/vomiting

Integumentary/Skin □ itching □ rash □ toenail changes □ ulcer/wound

Musculoskeletal □ ankle pain □ foot pain □ toe pain □ unsteady gait

Neurological □ numbness □ tingling

Respiratory □ shortness of breath

REASON FOR VISIT

FOOT & ANKLE SURGICAL GROUP

PHARMACY			
Pharmacy	Address	Zip	Phone

MEDICATIONS		

DRUG ALLERGIES		

MEDICAL CONDITIONS					
Anemia	□ Y □ N	Fibromyalgia	□ Y □ N	Peripheral Arterial Disease	□ Y □ N
Anxiety/Depression	□ Y □ N	Gout	□ Y □ N	Rheumatoid Arthritis	□ Y □ N
Arthritis	□ Y □ N	Heart Attack	□ Y □ N	Sickle Cell Disease	□ Y □ N
Atrial Fibrillation	□ Y □ N	Heart Disease/CHF	□ Y □ N	Skin Disorder	□ Y □ N
Back Problem	□ Y □ N	Hepatitis	□ Y □ N	Sleep Apnea	□ Y □ N
Bleeding Disorder	□ Y □ N	High Blood Pressure	□ Y □ N	Stomach Ulcers	□ Y □ N
Blood Clots/DVT/PE	□ Y □ N	High Cholesterol	□ Y □ N	Stroke	□ Y □ N
Cancer	□ Y □ N	HIV/AIDS	□ Y □ N	Thyroid Disease	□ Y □ N
Chronic Pain	□ Y □ N	Kidney Disease	□ Y □ N	Other	
COPD/Emphysema	□ Y □ N	Liver Disease	□ Y □ N		
Dermatitis/Psoriasis	□ Y □ N	Neuropathy	□ Y □ N		
Diabetes Mellitus	□ Y □ N	Pacemaker	□ Y □ N		

SURGICAL HISTORY		

SOCIAL HISTORY		
Marital Status	Employer	Occupation
Height	Weight	Shoe Size
Alcohol □ Never □ Occasional (how often):		
Tobacco □ Never smoker □ Former smoker □ Current, occasional smoker □ Current, every day smoker		
Current flu vaccination □ Y □ N	Current pneumonia vaccination (65 or older) □ Y □ N □ NA	
Do you have an Advanced Directive Plan □ Y □ N		

FAMILY HISTORY			
Condition	Father	Mother	Sibling
Cancer	□ Y □ N	□ Y □ N	□ Y □ N
Diabetes	□ Y □ N	□ Y □ N	□ Y □ N
Heart Disease	□ Y □ N	□ Y □ N	□ Y □ N

FOOT & ANKLE SURGICAL GROUP

CONSENT FOR TREATMENT

I authorize and consent to Foot & Ankle Surgical Group for medical treatment and/or procedures for myself or the patient for whom I am the parent or legally authorized representative. I understand no guarantee or assurance has been made as to the results for which may be obtained. I agree to allow the provider to access all medication history including medications prescribed by other providers.

Initials _____

PROTECTED HEALTH INFORMATION

I authorize Foot & Ankle Surgical Group to disclose my health care information and to discuss my health care needs with those I designate. I authorize the release of my billing information to these individuals as well. Without authorization, no information may be shared. I authorize Foot & Ankle Surgical Group to disclose my protected health information to the following people.

Name	Relationship	Phone
Name	Relationship	Phone

Initials _____

PRIVACY POLICY

I acknowledge Foot & Ankle Surgical Group has made available a copy of the "Privacy Practices," and I agree with these policies.

Initials _____

FINANCIAL RESPONSIBILTY & TERMS OF SERVICE

I authorize Foot & Ankle Surgical Group to release any medical information required during examination and treatment to my insurance company, and I authorize payment to Foot & Ankle Surgical Group from my insurance for any benefits due for services rendered. I understand Foot & Ankle Surgical Group submits insurance claims only as a courtesy, and I agree if my claim is denied it is still my responsibility whether my insurance company pays or not. I accept responsibility for services rendered regardless of insurance coverage. This includes but is not limited to co-insurance, co-payment, deductible, and non-covered services. I agree it is my responsibility to know my insurance benefits, and to obtain any referrals required by my insurance. I agree I am responsible for all charges incurred regardless of insurance status. I agree to pay my bill in full for services rendered by Foot & Ankle Surgical Group.

I agree it is my responsibility to notify Foot & Ankle Surgical Group of any changes in insurance, mailing address, and phone number(s).

I authorize Foot & Ankle Surgical Group to send any specimen to an outside lab.

I understand if my account is over 90 days past due Foot & Ankle Surgical Group can refer my account to a collection agency. I agree if my account is assigned to a collection agency, I am responsible to pay all expenses Foot & Ankle Surgical Group may incur in collecting the delinquent balance.

I agree I am responsible for a $25 charge for FMLA or similar paperwork. I agree I am responsible for charges incurred due to missed appointments or late cancellations. These include a $25 charge for general appointments and a $50 charge for in-office procedure/surgery appointments that are missed or cancelled within 24 hours of the appointment. These also include a $100 charge for outpatient surgery appointments that are missed or cancelled within 3 days of the appointment. I agree I am responsible for a $50 charge for all returned checks.

Initials _____

Sign (Patient or Guardian)	Date