

Family Foot & Ankle Center, P.A.

PATIENT INFORMATION

NAME: _____
Last First Middle
ADDRESS: _____

City State Zip
PHONE #: _____
BIRTHDATE: _____ AGE: _____
SEX: M ___ F ___ SOC. SEC. #: _____
SINGLE ___ MARRIED ___ OTHER ___
OCCUPATION: _____
EMPLOYER: _____
EMPLOYER ADDRESS: _____
WORK PHONE #: _____
SPOUSE'S NAME: _____
BIRTHDATE: _____ SS#: _____
SPOUSE'S EMPLOYER _____
EMP PHONE #: _____
SPOUSE'S OCCUPATION _____

INSURANCE INFORMATION

Person Responsible for Account

Address

Relationship to Patient

Method of Payment Medicare: _____ Medicaid _____
Cash _____ Insurance _____ Credit _____
INSURANCE COMPANY: _____
NAME OF INSURED: _____
POLICY #: _____ GROUP #: _____
BIRTHDATE: _____
IS PATIENT COVERED BY ADDITIONAL INS? _____
SUBSCRIBER: _____
BIRTHDATE: _____ SS#: _____
RELATIONSHIP TO PATIENT: _____
INSURANCE CO: _____ GROUP #: _____

REFERRED BY: _____

NAME OF RELATIVE OR FRIEND WHO CAN BE REACHED IN CASE OF EMERGENCY:

PHONE #: _____

ADDRESS: _____

I authorize FAMILY FOOT & ANKLE CENTER, PA (Dr. Douglas C. Smith or Dr. Patrick J. Dougherty, or whomever they designate) to administer treatment and to perform such general procedures as he (they) may deem necessary in the diagnosis and/or treatment of my foot condition. I further certify that to the best of my belief and knowledge the information provided on my personal health history is true and accurate. I also authorize the physician designated to release information acquired in the course of my examination and treatment.

I hereby assign payment directly to the designated physician for any medical/surgical procedures performed. I agree that this authorization shall be valid until rescinded in writing or replaced by one of a later date.

SIGNATURE: _____ **DATE:** _____

Patient acknowledgement of receiving notice of privacy policies

I hereby acknowledge that I have had the opportunity to read the notice of privacy practices and I am aware that I may receive a copy at my request.

SIGNATURE: _____ **DATE:** _____

MEDICAL HISTORY

NAME _____ DATE _____

YOUR MEDICAL DOCTOR'S NAME, PHONE AND ADDRESS _____

DATE OF LAST EXAM _____

WHAT PROBLEMS ARE YOU HAVING WITH YOUR FEET OR ANKLES? _____

WHAT MEDICATIONS DO YOU CURRENTLY USE ON A REGULAR BASIS OR ON AN OCCASSIONAL BASIS: _____

LIST RELATIONSHIP TO YOU OF IMMEDIATE FAMILY MEMBERS (MOTHER, FATHER, SIBLINGS) WHO HAVE HAD:

DIABETES _____ HEART DISEASE/ATTACKS _____
ARTHRITIS _____ HIGH BLOOD PRESSURE _____
STROKE _____ CANCER _____

ARE YOU NOW, OR MIGHT YOU BE PREGNANT? YES _____ NO _____

DO YOU SMOKE NOW? FORMER SMOKER _____ NO _____ YES _____ PACKS PER DAY _____ # OF YEARS _____

ALCOHOLIC BEVERAGE USE NONE _____ RARE _____ OCCASSIONAL _____ DAILY _____

LIST ANY EXCERCISE OR ATHLETIC ACTIVITIES YOU ARE ACTIVE IN _____

PERCENTAGE OF WAKING HOURS YOU SPEND ON YOUR FEET (CIRCLE ONE)

10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

DO YOU HAVE (PLEASE CIRCLE) ARTIFICIAL JOINTS, REPLACEMENT HEART VALVES, OR OTHER IMPLANTS

LIST PAST SURGERIES AND YEAR OF SURGERY _____

YOUR HEIGHT _____ YOUR WEIGHT _____ YOUR SHOE SIZE _____

DO YOU NOW OR HAVE YOU EVER BEEN TREATED FOR OR DIAGNOSED WITH THE FOLLOWING? PLEASE CIRCLE IF YES.

STROKE	CANCER	HIGH BLOOD PRESSURE
PHLEBITIS	HEART ATTACK	HEART CONDITION
DIABETES	ANEMIA	POOR CIRCULATION
HEPATITIS	ARTHRITIS	TUBERCULOSIS
GOUT	HIV/AIDS	NERVE DISORDER
ASTHMA	GLAUCOMA	KELOID/THICK SCAR
MIGRAINES	KIDNEY DISEASE	EPILEPSY/SIEZURES
LUNG DISEASE	LIVER DISEASE	THYROID DISORDER
REFLUX	SPINAL PROBLEMS	STOMACH ULCERS
PSYCHIATRIC DISORDER	OSTEOPOROSIS	HIGH CHOLESTEROL

OTHER(S) _____

NONE OF THE ABOVE _____

DO YOU HAVE ALLERGIES TO ANY OF THE FOLLOWING? PLEASE CIRCLE IF YES.

SULFA	PENICILLIN
CODEINE	ADHESIVE TAPE
IODINE	LOCAL ANESTHETICS
ASPIRIN	ANY OTHER MEDICATIONS _____

NO KNOWN ALLERGIES _____

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Dear Patients,

1. As the patient, you are responsible for full payment of your bill. However, as a courtesy, we will bill your health insurance carrier if all the necessary information is obtained on the date of service. If you do not have your insurance card it will be assumed that you do not have insurance and you will be responsible for your charges at this time.
2. If you are covered by more than one (1) insurance company, we will also file the second carrier as a courtesy as long as you have your insurance card so we can obtain the information needed for the file.
EXCEPTION: Medicare may not cross over to out of state Blue Cross Blue Shield. As a result we will courtesy file but we will collect the twenty percent (20%) for any Medicare claims and will reimburse if out of state Blue Cross pays.
3. If your deductible has not been met, we require payment at the time of service up to your deductible and then will collect your twenty percent (20%) or your percentage thereafter.
4. If your insurance company has not remitted payment forty-five (45) days after we have billed them, you will be notified. At that time, you will be asked to remit full payment on your account.

The patient is responsible for payment of the total charges shown on the bill. As a service to our patients, we file for insurance with your insurance carrier. We can not, however, guarantee payment of any of the charges shown on this bill. Payments will be shown on your account only after they are actually received by this office. The estimated amount due from the patient is based on a preliminary review of the patient's insurance coverage and is due from the patient or responsible party upon receipt of the bill. All overpayments will be refunded by check to the party due the overpayment.

If you wish to inquire as to why your insurance company has not paid, we suggest you do the following:

- Contact your insurance company at the number listed on your insurance card.
- Advise your insurance company that because of non-payment of your claim, payment is being requested in full.

Signature_____ Date_____