WELCOME TO ANP FOOT & ANKLE CLINIC

Patients First Name: _____ MI: _____ Last: _____ Sex: Male Female

Date Of Birth: _____ Soc. Sec. #: _____ Today's Date: _____

Nickname: _____ Marital Status: S M D W Spouse's Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Email: _____ Preferred Phone #: _____ Alternative Phone #: _____

May we leave a message on the phone? Yes No Comments: _____

In case of emergency, notfiy: _____ Phone: _____ Relationship: _____

FINANCIAL RESPONSIBILITY

Cash ☐

Person responsible for account:	Street Address (if different):	
Relationship to patient:	City, State:	Sex: Male Female
Preferred Phone #:	Soc. Sec. #:	ZIP:
Date of birth:	Work Phone #:	Employer:

PRIMARY INSURANCE

Company:	Date of birth for subscriber:
Subscriber:	Soc. Sec. #:

SECONDARY INSURANCE

Company:	Date of birth for subscriber:
Subscriber:	Soc. Sec. #:

SERVICES AND PERMISSION

I ACKNOWLEDGE THAT I WAS PROVIDED A COPY OF THE NOTICE OF PRIVACY PRACTICES AND THAT I HAVE READ (OR HAD THE OPPORTUNITY TO READ IF I SO CHOSE) AND UNDERSTOOD THE NOTICE.

I HEREBY AUTHORIZE SUCH MEDICAL, TREATMENT, AND DIAGNOSTIC TESTS AS MAY BE RECOMMENED BY THE ANP FOOT & ANKLE CLINICS, DOCTORS AND STAFF TO EXAMINE, DIAGNOSE AND TREAT MY PODIATRIC AILMENTS. I UNDERSTAND THERE IS NO WARRANTY OF RESULT OR CURE. THIS CONSENT WILL REMAIN IN EFFECT UNTIL I WITHDRAW W MY REQUEST IN WRITING.

I HEREBY REQUEST THAT THE PAYMENT OF AUTHORIZED INSURANCE/MEDICARE BENEFITS BE MADE DIRECTLY TO THE ANP FOOT & ANKLE CLINICS ON MY BEHALF FOR ANY SERVICES PROVIDED TO ME BY ANP FOOT & ANKLE CUNICS. I AUTHORIZE ANP FOOT & ANKLE CLINIC'S DOCTORS AND STAFF TO RELEASE ANY MEDICAL OR OTHER INFORMATION ABOUT ME, NEEDED TO DETERMINE THE BENEFITS FOR THE SERVICES, TO THE HEALTH CARE FINANCING ADMINISTRATION AND OR MY HEALTH INSURANCE COMPANY AND ITS AGENTS.

I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT PAID BY INSURANCE; AND I AM SUBJECT TO ANY LATE OR SERVICE FEES FOR ANY UNPAID BALANCE. I AUTHORIZE THE USE OF MY SIGNATURE ON ALL INSURANCE SUBMISSIONS.

Please print patient's name: _____

Signature of patient, parent, guardian: _____ Date: _____

ALLERGIES

Yes No

If yes:

1. _____
2. _____
3. _____
4. _____
5. _____

MEDICATIONS (WITH DOSAGES)

Yes No

If yes:

1. _____
2. _____
3. _____
4. _____
5. _____

PHARMACY

Pharmacy Name: _____

Street: _____

State: _____ Zip: _____

Address 2 (if applicable)

Street: _____

State: _____ Zip: _____

TODAY'S VISIT

What brings you by the office today? _____

Left Foot Right Foot Both How long has it been going on? _____

How severe is the pain? 1 2 3 4 5 6 7 8 9 10

Comments: _____

Name of family/regular doctor: _____

GENERAL HEALTH

AIDS
Alcoholism
Alzheimers
Anemia
Arthritis (Rheumatoid)
Asthma
Smoker (Current or Former)
High Blood Pressure
Depression/Anxiety
Heart Attack
Neck Pain
Back Pain
Hip Pain
Ulcers
Gout
Knee Pain
Ankle Pain
Diabetes
Drug Abuse
Plantar Fasciitis
Seizures
Kidney
Stroke
Cancer _____
COPD
Hepatitis (A) (B) (C)
Aching Feet
Other Health Problems:

SURGICAL HISTORY

Carpal Tunnel
Gallbladder
Appendix
Shoulder
Ankle
Knee
Hip
Pacemaker
Stent
Cardiac (Heart)
Back
Thyroid
Hernia
Vascular
Foot Surgery
Other Surgeries:

SUBMIT