 Patient Information Form

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Phone :(\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell: (\_\_\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work: (\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Preferred method of Contact: Letter\_\_\_\_ Email\_\_\_\_\_

Permanent Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City:\_\_\_\_\_\_\_\_\_\_\_\_\_Zip:\_\_\_\_\_\_\_\_\_\_\_

Local Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City:\_\_\_\_\_\_\_\_\_\_\_\_\_Zip:\_\_\_\_\_\_\_\_\_\_\_

Sex: M\_\_\_\_ F\_\_\_\_\_ Birth Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

In case of Emergency who should be notified? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone:(\_\_\_\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Who may we thank for referring you? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How did you find us? ☐ Insurance ☐ Yellow Pages ☐ Advertisement ☐ Referral (Who?)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

☐ Internet (What did you search?)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ☐ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Additional Information

Primary Care Physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_PCP Phone:(\_\_\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Pharmacy Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cross Streets: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

U.S. Department of Health and Human Services Assessment

*The answers to the following questions are optional: Race, Ethnicity, Preferred Language.*

Preferred Language:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Race:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Ethnicity:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Primary Insurance Secondary Insurance

I gave a copy of my Primary Insurance Card (Y) / (N) I gave a copy of my Secondary Insurance Card (Y) / (N)

|  |  |
| --- | --- |
| Policy Holders Name: | Policy Holders Name: |
| Policy Holders DOB: | Policy Holders DOB: |
| Relationship to Patient: | Relationship to Patient: |
| Address (*if different from patients*) | Address (*if different from patients*) |
|  |  |
| Insurance Company Name: | Insurance Company Name: |
| Policy or ID #: | Policy or ID #: |
| Group #: | Group #: |

Who may receive information regarding your Protected Health Information? Check all that apply

Spouse\_\_\_\_\_Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date of Birth:\_\_\_\_\_\_\_\_\_\_\_\_\_

Children\_\_\_\_Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date of Birth:\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/Gaurdian\_\_\_\_Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date of Birth:\_\_\_\_\_\_\_\_\_\_\_\_\_

Significant Other/Friend\_\_\_\_\_\_Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date of Birth:\_\_\_\_\_\_\_\_\_\_\_\_\_

May we leave messages regarding test results and appointments on your answering machine? \_\_\_\_Yes \_\_\_\_\_No

Assignment and Release

I certify that I, and or my dependent(s) have insurance coverage and assign all benefits directly to the office of *AllCare Foot & Ankle, LLC*. I understand I will be responsible for any portion of the claim, which is denied or not covered by my insurance company. I authorize the release to my insurance carriers any information necessary to process this claim.

ACKNOWLEDGEMENT OF REVIEW OF NOTICE OF PRIVACY PRACTICES:

I have received a copy of the Privacy Rules from this provider and authorized the above list of persons who may receive my Protected Health Information. I may revoke this at any time by giving written notification to this provider.

Signed: Date:

 New Patient Information Form

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Primary Care Doctor: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Referred By: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please explain why you are here today. (Pain, fracture, injury, etc.) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you seen any other doctor for this or any other foot/ankle problem? Which Doctor? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you grant permission for this office to retrieve records from your previous treating physician? ☐YES ☐NO

Past of Current Medical Conditions

☐Addiction to Alcohol ☐Arthritis (Rheumatoid) ☐Diabetes Type I or II ☐High Cholesterol

☐Addiction to Narcotic ☐Arthritis (Osteo) ☐GI Problems (ulcers, IBS, reflux) ☐Kidney Disorder

☐AIDS/HIV ☐Cancer ☐Heart Disease ☐Liver Disease

☐Anesthesia Problems ☐Chronic Pain ☐High Blood Pressure ☐Vascular Disease

Please list any other medical problems: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Surgical History

Please list all surgical procedures you have had: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |  |
| --- | --- | --- | --- |
| Please list all current medications:  (Please include all vitamins and minerals) | | Family History (please select all that apply)  Mother Father Grandparent  Anesthesia Problems ☐ ☐ ☐  Arthritis (Rheumatoid) ☐ ☐ ☐  Arthritis (Osteo) ☐ ☐ ☐  Cancer ☐ ☐ ☐  Diabetes Type I or II ☐ ☐ ☐  Heart Disease ☐ ☐ ☐  High Blood Pressure ☐ ☐ ☐  High Cholesterol ☐ ☐ ☐ Vascular Disease ☐ ☐ ☐ | |
| Allergies:  ☐None ☐Latex  ☐Iodine ☐Metals (rash or blister with jewelry)  ☐Codeine ☐Local Anesthetics  ☐Sulfa ☐Penicillin  Please list any other allergies: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | Social History:  Tobacco Use ☐Yes ☐No How Much \_\_\_\_\_\_\_\_\_\_\_\_  How Long \_\_\_\_\_\_\_\_\_\_\_\_\_  Alcohol Use ☐Yes ☐No How Often \_\_\_\_\_\_\_\_\_\_\_\_  Rec. Drugs ☐Yes ☐No Which drugs \_\_\_\_\_\_\_\_\_\_\_  Currently Pregnant ☐Yes ☐No Due Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| Review of Systems: (Check any of the following that you have, or have had in the past) | | | |
| ☐ Weight Loss | ☐ Chest Pain | ☐ Muscle Weakness | ☐ Frequent Urination |
| ☐ Weight Gain | ☐ Irregular Heartbeat | ☐ Rashes | ☐ Burning with Urination |
| ☐ Fatigue | ☐ Shortness of Breath | ☐ Sores | ☐ Hair Loss |
| ☐ Blurry Vision | ☐ Trouble Breathing | ☐ Numbness | ☐ Excessive Thirst |
| ☐ Double Vision | ☐ Cough | ☐ Poor Balance | ☐ Easy Bruising |
| ☐ Ringing in ears | ☐ Upset Stomach | ☐ Diarrhea | ☐ Bloody Stools |
| ☐ Hearing Loss | ☐ Bloody Nose | ☐ Loss of Taste | ☐ Sinus Congestion |
| ☐ Anxiety/Depression | ☐ Dry Mouth/Sore Throat | ☐ Joint Pain/Stiffness | ☐ Food/Seasonal Allergies |

 Patient Financial Responsibility

Patient Name:

I HEREBY AUTHORIZE MY INSURANCE COMPANY TO MAKE PAYMENTS DIRECTLY TO:

AllCare Foot & Ankle, LLC

I understand that I am financially responsible for any co-payments, deductibles, co-insurance, and all charges, which are not covered by my insurance. I understand that there will be a $25.00 service charge on all returned checks. I understand that verification of benefits is not a guarantee of payment. (Insurance benefits are determined by your insurance company when the claim is received.) I understand that I will be responsible for any portion of the claim that is allowed by, but not covered by, my insurance company. Initial: With the exception of Medicare, I understand that if I have secondary insurance, I am responsible for payment of my co-insurance at the time service is rendered. I understand that, upon request, I will be provided with all required documentation to collect reimbursement myself.

I understand that I am responsible for all charges if it is determined that the insurance information I have provided is not correct

Delinquent accounts will be turned over to a collection agency without notice. Accounts will be considered delinquent if unpaid after 60 days. In the event my account is turned over for collection, I will pay all reasonable collection, court and attorney costs at the time the account is considered delinquent.

Signature of Responsibility Party Printed Name of Responsibility Party Date

RELEASE OF INFORMATION:

I hereby authorize AllCare Foot & Ankle, LLC to release any medical information or incidental information to my referring physician or any other physician who have been or may become involved in my care.

Signature of Responsibility Party Printed Name of Responsibility Party Date