AllCare Foot & Ankle, LLC

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

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

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

Secondary Insurance

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

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

AllCare Foot & Ankle, LLC

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

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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