ANKLE & FOOT SPECIALISTS OF SOUTHERN OREGON

PATIENT INTAKE FORM

PATIENT INFORMATION

NAME: _____
LAST FIRST MIDDLE

ADDRESS: _____
STREET CITY STATE ZIP

SEASONAL ADDRESS: _____
STREET CITY STATE ZIP

DATES AT SEASONAL ADDRESS: _____ (Month) I'hru _____ (Month) PREFERRED WAY TO CONTACT YOU: ❑ HOME ❑ WORK ❑ CELL

PHONE: HOME ( ) _____ WORK ( ) _____ CELL ( ) _____

EMAIL: _____ I AUTHORIZE EMAIL CONTACT: ❑ YES ❑ NO

DATE OF BIRTH: _____ AGE: _____ SOCIAL SECURITY №: _____

SEX: ❑ MALE ❑ FEMALE MARITAL STATUS: ❑ MARRIED ❑ SINGLE ❑ SEPARATED ❑ OTHER

PRIMARY CARE PHYSICIAN: _____ PHYSICIAN PHONE №: _____

EMPLOYED: ❑ YES ❑ NO EMPLOYER: _____ OCCUPATION: _____

EMERGENCY CONTACT: _____ PHONE: ( ) _____
NAME / RELATION

THE ABOVE INFORMATION PERTAINS TO THE PATIENT ONLY. IF THE PATIENT IS A MINOR OR UNDER THE SUPERVISION OF A LEGAL GUARDIAN, THEN THE RESPONSIBLE PARTY MUST COMPLETE THE FOLLOWING SECTION. IF THIS DOES NOT APPLY, THEN YOU MAY SKIP TO THE NEXT SECTION.

GUARANTOR INFORMATION

NAME: _____
LAST FIRST MIDDLE

ADDRESS: _____
STREET CITY STATE ZIP

PHONE: HOME ( ) _____ WORK ( ) _____ CELL ( ) _____

DATE OF BIRTH: _____ AGE: _____ SOCIAL SECURITY №: _____

EMPLOYED: ❑ YES ❑ NO EMPLOYER: _____ OCCUPATION: _____

INSURANCE INFORMATION

ARE YOU AWARE OF YOUR INSURANCE BENEFITS? ❑ YES ❑ NO

PRIMARY INSURANCE NAME: _____ POLICY ID # / GROUP #: _____

INSURED NAME: _____ EMPLOYER: _____

DATE OF BIRTH: _____ AGE: _____ SOCIAL SECURITY №: _____

SECONDARY INSURANCE NAME: _____ POLICY ID # / GROUP #: _____

INSURED NAME: _____ EMPLOYER: _____

DATE OF BIRTH: _____ AGE: _____ SOCIAL SECURITY №: _____

MEDICAL HISTORY

EXPLAIN YOUR FOOT / ANKLE PROBLEM: _____

_____

_____

WHEN DID SYMPTOMS FIRST APPEAR OR ACCIDENT OCCUR (**DATE**)? _____

PLEASE DESCRIBE YOUR PAIN / DISCOMFORT: ❑ BURNING ❑ NUMBNESS ❑ SHARP ❑ OTHER _____

WHAT MAKES YOUR PAIN / DISCOMFORT BETTER? _____

WHAT MAKES YOUR PAIN / DISCOMFORT WORSE? _____

HAS THIS CONDITION BEEN PREVIOUSLY TREATED? ❑ YES ❑ NO HOW AND WHEN? _____

HAVE YOU HAD PRIOR SURGERY ANYWHERE ON YOUR BODY? ❑ YES ❑ NO IF YES, ***PLEASE LIST TYPE AND DATE OF SURGERY:***

1.	2.	3.	4.	5.	6.
7.	8.	9.	10.	11.	12.

HEIGHT	WEIGHT	SHOE SIZE

DO YOU TAKE MEDICATION ON A DAILY BASIS, INCLUDING PILLS, INJECTABLES, OR HERBS? ❑ YES ❑ NO ❑ SEE ATTACHED LIST

PLEASE LIST:

PHARMACY NAME: _____ PHARMACY #: _____

1.	2.	3.	4.	5.	6.
7.	8.	9.	10.	11.	12.

CONTINUED ON NEXT PAGE

ARE YOU BEING TREATED FOR OR HAVE BEEN TREATED FOR ANY OF THE FOLLOWING?

ALCOHOLISM	❑ YES	❑ NO	HEART ATTACK	❑ YES	❑ NO
ANEMIA	❑ YES	❑ NO	HEPATITIS OR JAUNDICE	❑ YES	❑ NO
ARTHRITIS	❑ YES	❑ NO	HIGH BLOOD PRESSURE	❑ YES	❑ NO
ASTHMA	❑ YES	❑ NO	HIV / AIDS	❑ YES	❑ NO
BRONCHITIS OR EMPHYSEMA	❑ YES	❑ NO	KIDNEY TROUBLE	❑ YES	❑ NO
CANCER OR TUMOR	❑ YES	❑ NO	MITRAL VALVE PROLAPSE	❑ YES	❑ NO
CHOLESTEROL / TRIGLYCERIDES	❑ YES	❑ NO	RHEUMATIC FEVER	❑ YES	❑ NO
DIABETES	❑ YES	❑ NO	STOMACH ULCERS	❑ YES	❑ NO
Last Blood Sugar # / A1C_____ How Long?_____			STROKE	❑ YES	❑ NO
DRUG ABUSE	❑ YES	❑ NO	THROMBOPHLEBITIS	❑ YES	❑ NO
EPILEPSY OR SEIZURE	❑ YES	❑ NO	THYROID DISEASE	❑ YES	❑ NO
GOUT	❑ YES	❑ NO	TUBERCULOSIS	❑ YES	❑ NO

ARE YOU <u>ALLERGIC</u> TO OR HAVE YOU EVER REACTED TO ANY OF THE FOLLOWING?

ANTIBIOTICS / PENICILLIN	❑ YES	❑ NO	GENERAL ANESTHESIA	❑ YES	❑ NO
ASPIRIN	❑ YES	❑ NO	LIDOCAINE/NOVACAINE (LOCAL ANESTHESIA)	❑ YES	❑ NO
BAND AIDS / TAPE	❑ YES	❑ NO	RADIOGRAPHIC CONTRAST / DYE	❑ YES	❑ NO
CODEINE	❑ YES	❑ NO	SEDATIVE	❑ YES	❑ NO
IODINE	❑ YES	❑ NO	SULFA DRUGS	❑ YES	❑ NO
			LATEX	❑ YES	❑ NO

Other not listed? _____

SOCIAL HISTORY:

DO YOU USE TOBACCO?	❑ YES	❑ NO	DO YOU USE RECREATIONAL DRUGS?	❑ YES	❑ NO
IF YES, HOW MANY PACKS PER DAY AND FOR HOW LONG?	_____/_____		DO YOU EXERCISE ON A REGULAR BASIS?	❑ YES	❑ NO
ARE YOU PREGNANT?	❑ YES	❑ NO	ARE YOU NURSING?	❑ YES	❑ NO
IF YES, DELIVERY DATE?	_____				
DO YOU DRINK ALCOHOL?	❑ YES	❑ NO	DO YOU DRINK CAFFEINE?	❑ YES	❑ NO

FAMILY HISTORY

PLEASE LIST YOUR RELATIONSHIP TO THE FAMILY MEMBER WHO HAS HAD THE FOLLOWING PROBLEMS:

BLEEDING DISORDERS	❑ YES	❑ NO	_____	KIDNEY DISEASE	❑ YES	❑ NO	_____
CANCER	❑ YES	❑ NO	_____	MENTAL ILLNESS	❑ YES	❑ NO	_____
DIABETES	❑ YES	❑ NO	_____	RHEUMATOLOGY	❑ YES	❑ NO	_____
HEART DISEASE	❑ YES	❑ NO	_____	STROKE	❑ YES	❑ NO	_____
HIGH BLOOD PRESSURE	❑ YES	❑ NO	_____	OTHER			_____

OUR OFFICE GROWS MAINLY BY REFERRAL FROM OTHER PATIENTS. WHOM MAY WE THANK FOR REFERRING YOU TO OUR OFFICE?_____

Review of Systems

CARDIOVASCULAR: ❑ **NONE**
- ❑ CALF PAIN WITH EXERCISE / WHILE SLEEPING
- ❑ CHEST PAIN / HEART ATTACK
- ❑ CONGESTIVE HEART FAILURE
- ❑ HEART FAILURE
- ❑ PALPITATIONS

CONSTITUTIONAL SYMPTOMS: ❑ **NONE**
- ❑ FEVER
- ❑ CHILLS
- ❑ SWEATS
- ❑ WEIGHT LOSS

ENDOCRINE: ❑ **NONE**
- ❑ EXCESS SWEATING
- ❑ FREQUENT/DIFFICULTY URINATING
- ❑ OFTEN FEELING HOT/COLD
- ❑ OFTEN HUNGRY
- ❑ OFTEN THIRSTY
- ❑ PANCREATITIS
- ❑ PROSTATE PROBLEMS

GASTROINTESTINAL: ❑ **NONE**
- ❑ ACID REFLUX
- ❑ BLOOD IN STOOL
- ❑ CONSTIPATION
- ❑ DECREASE IN APPETITE
- ❑ DIARRHEA
- ❑ NAUSEA
- ❑ VOMITING

HEAD, EYES, EARS, NOSE, AND THROAT: ❑ **NONE**
- ❑ CATARACTS
- ❑ CONTACTS
- ❑ DENTURES
- ❑ DIFFICULTY SWALLOWING
- ❑ DIZZINESS
- ❑ DOUBLE VISION
- ❑ EYEGLASSES
- ❑ NECK PAIN
- ❑ NOSE BLEED
- ❑ RINGING IN EARS
- ❑ SORE THROAT

HEMATOLOGICAL/LYMPHATIC: ❑ **NONE**
- ❑ BLEEDING ABNORMALITIES
- ❑ LUMP IN GROIN/ARMPIT
- ❑ SWOLLEN GLANDS

INTEGUMENTARY (SKIN): ❑ **NONE**
- ❑ BIRTHMARKS
- ❑ CHANGES IN SKIN COLOR
- ❑ ECZEMA
- ❑ GROWTH ON SKIN
- ❑ HAIR LOSS
- ❑ LESIONS
- ❑ PIERCING
- ❑ RASH
- ❑ RECURRENT INFECTIONS
- ❑ SENSITIVITY TO SUNLIGHT
- ❑ TATTOOS
- ❑ SKIN ULCERS / WOUNDS IN THE PAST

MUSCULOSKELETAL: ❑ **NONE**
- ❑ BURSITIS
- ❑ JOINT PAIN/SWELLING/STIFFNESS
- ❑ PRIOR FRACTURE/SPRAINS
- ❑ TENDONITIS
- ❑ WEAKNESS OF LIMBS

NEUROLOGICAL: ❑ **NONE**
- ❑ CONFUSION
- ❑ FAINTING
- ❑ INSOMNIA
- ❑ NERVOUS DISORDERS
- ❑ NEUROPATHY (LOSS OF SENSATION)
- ❑ MIGRAINES
- ❑ SPEECH DIFFICULTIES
- ❑ POOR BALANCE

PSYCHIATRIC: ❑ **NONE**
- ❑ DEPRESSION
- ❑ NERVOUSNESS
- ❑ TENSION

RESPIRATORY: ❑ **NONE**
- ❑ COUGH
- ❑ DIFFICULTY BREATHING
- ❑ SHORTNESS OF BREATH
- ❑ WHEEZING

To the best of my knowledge, the questions above were accurately answered. I understand that providing inaccurate information can be dangerous to my health.

Patient name and signature of patient / parent / POA: _____

Physician's review: _____ _____
(Signature) *(Date)*

ANKLE & FOOT SPECIALISTS OF SOUTHERN OREGON

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Ashland, Oregon 97520
541 482 4924

FINANCIAL POLICY

In the interest of good health care practice, it is desirable to establish a Financial Policy to avoid misunderstandings. We are committed to providing you with the best possible care. If you have insurance, we are happy to help you receive the maximum allowable benefit. In order to achieve these goals, we need your assistance and understanding of our payment policy. For the convenience of our patients, we offer the following methods of payments.

- Payment in full by cash, credit/debit card, check, or money orders at the time services are rendered. A 20% discount is offered when payment is received in full.
- For those patients that have insurance, we will accept payment directly from the insurance company- only for that percentage the insurance company will cover. **Your co-pay is due at the time of each visit.**

It is important that you realize…

- Your insurance benefit is a contract between you, your employer (if applicable), and the insurance company. **We are not a party to that contract.** This office files you insurance claims as a courtesy to you. We will bill your PRIMARY and SECONDARY medical insurance **as long as they are provided at the time treatment begins.**
- If your insurance plan requires a referral from you Primary Care Provider, we ask that you phone your Primary Care Provider prior to you appointment for the necessary authorization, *lack of referral could result in patient responsibility for services requested on that day.*
- Our fees generally, but not necessarily, call within the usual and customary fee structure determined by your insurance company.
- **NOT ALL SERVICES ARE A COVERED BENEFIT IN ALL CONTRACTS.**
- We do recommend that you contract your insurance company to verify benefits for treatment our physicians my recommend.
- If you are UNINSURED or if this is a THIRD PARTY CLAIM, payment in full is expected for services rendered at the time of your visit. Monthly payments can be arranged, but it is **YOUR** responsibility to maintain that arrangement. If the medical problem for which you are seeing the physician involves an attorney, timely payments must still be made. We **DO NOT** wait for payment until the time of settlement is reached.

There is a $25 fee on all returned checks. Interest may accrue to accounts that become delinquent. After 90 days, accounts are subject to collections.

I have read this Financial Policy and understand that regardless of any insurance coverage I may have, I am responsible for payment on my account. I understand that delinquent accounts may be assigned to a collection agency. Also, if it becomes necessary to effect collections of any amount owe on this or subsequent visits, the undersigned agree to pay for all cost and expenses, including reasonable attorney fees. I herby authorize Ankle & Foot Specialists of Southern Oregon to release information necessary to secure payment.

_____ _____

Signature of Patient OR Responsible Party Date