



PATIENT INFORMATION

Male Female Minor Married Single

Today's Date: _____ SSN: _____ Birthday: _____
(Required for adults)

Name: _____
Last Name First Name Middle Name

Address: _____

City: _____ State: _____ Zip: _____

Primary Phone: _____ 2nd Phone: _____

Email Address: _____

Employer: _____ Occupation: _____

Primary Language: _____ Hispanic? Yes / No

How did you learn about our office? _____

What is your primary concern with your feet today? _____

SPOUSE/ PARENT INFORMATION

Male Female Parent Married

Spouse/ Parent's Name: _____ Birthday: _____

Phone # _____ SSN: _____
If Different From Above

Address: _____
If Different From Above City State Zip Code

Employer: _____ Occupation: _____

MEDICAL INFORMATION

Who is your primary care doctor? _____

Pharmacy: _____ Town: _____

Medications	Dosage	Medications	Dosage
1.		6.	
2.		7.	
3.		8.	
4.		9.	
5.		10.	

Current Podiatric Problem

<u>Location:</u> <input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Both <input type="checkbox"/> Achilles <input type="checkbox"/> Ankle <input type="checkbox"/> Arch <input type="checkbox"/> Ball of Foot <input type="checkbox"/> Big Toe <input type="checkbox"/> Big Toe Nail <input type="checkbox"/> Heel <input type="checkbox"/> Smaller Toes <input type="checkbox"/> Smaller Toe Nails <input type="checkbox"/> Top of Foot <input type="checkbox"/> Other: _____	
<u>Nature:</u> <input type="checkbox"/> Aching <input type="checkbox"/> Bruised <input type="checkbox"/> Burning <input type="checkbox"/> Cramping <input type="checkbox"/> Deep <input type="checkbox"/> Dull <input type="checkbox"/> Improving <input type="checkbox"/> Inflamed <input type="checkbox"/> Itchy <input type="checkbox"/> Numbness <input type="checkbox"/> Pressure <input type="checkbox"/> Sharp <input type="checkbox"/> Shooting <input type="checkbox"/> Sore <input type="checkbox"/> Swollen <input type="checkbox"/> Tender <input type="checkbox"/> Tight <input type="checkbox"/> Tingling	
<u>Started:</u> <input type="checkbox"/> Today <input type="checkbox"/> # ____ days <input type="checkbox"/> # ____ weeks <input type="checkbox"/> # ____ months <input type="checkbox"/> # ____ years ago	<u>Timing:</u> <input type="checkbox"/> Barefoot <input type="checkbox"/> Constant <input type="checkbox"/> Evening <input type="checkbox"/> In Shoes <input type="checkbox"/> Intermittently <input type="checkbox"/> Morning <input type="checkbox"/> Running <input type="checkbox"/> Standing <input type="checkbox"/> Walking
<u>Cause:</u> <input type="checkbox"/> Unknown <input type="checkbox"/> Developed gradually <input type="checkbox"/> Injury: _____	<u>Treatment:</u> <input type="checkbox"/> Compression <input type="checkbox"/> Elevation <input type="checkbox"/> Heat <input type="checkbox"/> Ice <input type="checkbox"/> Medication <input type="checkbox"/> Rest <input type="checkbox"/> Stretching <input type="checkbox"/> Shoe Change

Ongoing Medical Conditions/ Past Medical History

<input type="checkbox"/> NONE <input type="checkbox"/> Cancer <input type="checkbox"/> Gout <input type="checkbox"/> Lung Disease <input type="checkbox"/> Seizure Disorders <input type="checkbox"/> Anxiety <input type="checkbox"/> Chemotherapy <input type="checkbox"/> Heart Attack <input type="checkbox"/> Lupus <input type="checkbox"/> Sports Related Injury <input type="checkbox"/> Arthritis <input type="checkbox"/> Circulation Problems <input type="checkbox"/> Heart Disease <input type="checkbox"/> Neuropathy <input type="checkbox"/> Stomach Ulcers <input type="checkbox"/> Asthma <input type="checkbox"/> Depression <input type="checkbox"/> Hepatitis type: _____ <input type="checkbox"/> MRSA Infection <input type="checkbox"/> Stroke <input type="checkbox"/> Bleeding Disorder <input type="checkbox"/> Diabetes (Insulin) <input type="checkbox"/> Diabetes (non-Insulin) <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Osteoporosis <input type="checkbox"/> Swelling in Legs/Feet <input type="checkbox"/> Blood Clots <input type="checkbox"/> Kidney Disease <input type="checkbox"/> Pain in Legs/Feet/Toes <input type="checkbox"/> Thyroid Disorders <input type="checkbox"/> Callus Formation <input type="checkbox"/> Foot Ulcerations <input type="checkbox"/> Liver Disease <input type="checkbox"/> RSD/CRPS <input type="checkbox"/> Other: _____
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Previous Surgeries

<input type="checkbox"/> NONE <input type="checkbox"/> Amputation <input type="checkbox"/> Angioplasty/stent <input type="checkbox"/> Appendectomy <input type="checkbox"/> Back/spine <input type="checkbox"/> Blood Transfusion <input type="checkbox"/> Bunion <input type="checkbox"/> Carpal Tunnel <input type="checkbox"/> Cataracts <input type="checkbox"/> Gallbladder <input type="checkbox"/> Gastric Bypass <input type="checkbox"/> Hammer Toe <input type="checkbox"/> Heart Bypass <input type="checkbox"/> Heart Valve Replacement <input type="checkbox"/> Hysterectomy <input type="checkbox"/> Ingrown Nail <input type="checkbox"/> Joint Replacement: _____ <input type="checkbox"/> Lap Band <input type="checkbox"/> Lower Extremity Bypass <input type="checkbox"/> Neuroma <input type="checkbox"/> Pacemaker <input type="checkbox"/> Tonsils <input type="checkbox"/> Transplant: _____ <input type="checkbox"/> Other: _____
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Family Medical History

<u>Biological Family</u>	<u>Mother</u>	<u>Father</u>	<u>Sibling</u>	<u>Grandparent</u>	<u>Alcohol Consumption</u>	<u>Smoking</u>
None	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> None	<input type="checkbox"/> Never
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Occasional	<input type="checkbox"/> Former
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Daily	<input type="checkbox"/> Daily
Hypertension	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> Social

Social History**Review of Systems**

Psychiatric: Dementia Schizophrenia Anxiety Bipolar ADD Mental Retardation

Head & Eyes: Dizziness Fainting Headaches Double Vision Infection

Ears, Nose & Throat: Pain in Ears Sores Infection Pain Swallowing Hoarseness Ringing Ears
 Nose Bleed (within 7 days)

Respiratory: Bronchitis Painful Breathing Coughing Blood Emphysema
 Difficulty Breathing (unless sitting up)

Cardiovascular: Phlebitis Hypertension Heart Murmur Shortness of Breath Chest Pain Edema
 SOB with Exertion Palpitations Claudicating Atrial Fib Ulceration Congestive Heart Failure

Endocrine: Diabetic Borderline Diabetic Hypothyroid Hyperthyroid Addison's Disease
 Cushing Syndrome Other: _____

Gastrointestinal: Jaundice Cirrhosis Abnormal Stools GI Ulcers Nausea Vomiting

Genitourinary: Frequent Urination Incontinence Frequent UTI's Renal Dialysis

Musculoskeletal: Joint Pain Joint Swelling Muscle Pain Heel Pain With Standing After Rest
 Joint Disability Weakness Back Pain Osteoarthritis

Dermatologic: Skin Infection Psoriasis Spider Veins Blisters Athletes Foot Macerated Webspace
 Rash Bleeding Bruising Itching Excessively Thick Nails Foot Ulcer Keloid: _____

Neurologic: Loss of Muscle Function Tics Tremors Seizures Foot Numbness
 Tingling Hands or Feet

Allergic Immunologic: Seasonal Allergies Anaphylactic Reaction: _____
 HIV Immune System Suppression Recurring Infection Rheumatoid Arthritis Fibromyalgia

Hematology/ Oncology: Sickle Cell Anemia Anemia Leukemia Current Chemo Therapy

Allergies

NONE

Adhesive/tape Local Anesthetics Aspirin Blood Thinners Codeine Demerol Iodine Sulfa

IV Contrast Dye Latex Penicillin Shellfish Other: _____

Height: _____ Weight: _____ Shoe Size: _____

The above information is completed correctly to the best of my knowledge. I also understand it is my responsibility to inform this office of any changes associated with this form.

Signature of Responsible Party: _____ Date: _____

PRIMARY INSURANCE

Insurance Company: _____

Subscriber ID# _____ Group# _____

Fill the following section out if insured is someone other than the patient.

Primary Member's Name: _____
Last Name First Name Middle

Relationship to Patient: _____ Birthday: _____ SSN: _____

SECONDARY INSURANCE

Insurance Company: _____

Subscriber ID# _____ Group# _____

Fill the following section out if insured is someone other than the patient.

Primary Member's Name: _____
Last Name First Name Middle

Relationship to Patient: _____ Birthday: _____ SSN: _____

EMERGENCY CONTACT

Who should we contact? _____

Primary phone: _____ Secondary phone: _____

PRIVACY RIGHTS

I acknowledge that Total Foot and Ankle is compliant with the Federal Privacy laws. I understand this Privacy Notice, and I had the opportunity to read the Federal Privacy Act or keep a copy of it if I so chose.

Patient Signature (or guardian if minor): _____ Date: _____

Print Patient Name: _____

FINANCIAL POLICY

Your insurance policy is a contract between you and your insurance company. As a courtesy, we will file your insurance claim for you if you assign the benefits to the doctor. In other words, you agree to have your insurance company pay the doctor directly. If your insurance company does not pay the practice within a reasonable period, you are ultimately responsible for payment.

You are responsible for all authorizations/referrals that may be needed to seek treatment in this office.

All co-payments, deductibles, and any co-insurance must be paid at the time of service. You are responsible for any non-covered services you choose to receive. You must pay for these services in full at the time of the visit.

Non-covered items will not be billed to your insurance.

We accept Cash, Checks, MasterCard, Visa, Discover, and Care Credit.

Returns must be in "Like New" condition. If any signs of wear, soiling, use, etc. are found on the item, it will not be accepted. Returns are only accepted within 2 weeks from the date of purchase. All returns are subject to a \$10.00 restocking fee. Custom items can be adjusted but cannot be returned.

Balance after insurance is due within 30 days. Any balance that is not paid within 90 days will be subject to a rebilling fee for each outstanding month until paid. At the end of 120 days, the account will be turned over for collections. Any cost to collections will be added to your bill.

- All returned checks will be subject to a \$25.00 returned check fee.
- Completion of all forms, such as disability applications, etc will require a \$10.00 fee.

Responsible Party Signature

Date

Print Name of Responsible Party

MEDICAL RECORDS RELEASE

I give Total Foot and Ankle permission to share my medical records with the following person(s).
I will not hold Total Foot and Ankle responsible for any misuse of this information. Optional.

Name: _____ Relation: _____ Phone# _____

Patient Signature: _____ Date: _____

ASSIGNMENT & RELEASE

I hereby give permission to Total Foot and Ankle (TFAA) & staff to perform minor diagnostic treatment as may be deemed necessary to diagnose and/or treat the patients' foot/ankle condition. I authorize the release of any medical information necessary to process this claim and request payment of benefits, either to myself or to the party who accepts assignment. I authorize TFAA office and/or any provider or supplier of services to release the information to secure the payment of benefits. I further authorize TFAA office staff to act on my behalf concerning any and all claims connected to TFAA. I authorize the use of this signature on all submissions.

Signature of Responsible Party _____

Date: _____