TOTAL FOOT AND ANKLE ENID

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

Location: ❑ Right ❑ Left ❑ Both

❑ Achilles ❑ Ankle ❑ Arch ❑ Ball of Foot ❑ Big Toe ❑ Big Toe Nail ❑ Heel ❑ Smaller Toes ❑ Smaller Toe Nails

❑ Top of Foot ❑ Other: _____

Nature: ❑ Aching ❑ Bruised ❑ Burning ❑ Cramping ❑ Deep ❑ Dull ❑ Improving ❑ Inflamed ❑ Itchy

❑ Numbness ❑ Pressure ❑ Sharp ❑ Shooting ❑ Sore ❑ Swollen ❑ Tender ❑ Tight ❑ Tingling

Started: ❑ Today ❑ # _____ days

❑ # _____ weeks ❑ # _____ months

❑ #_____ years ago

Timing: ❑ Barefoot ❑ Constant ❑ Evening

❑ In Shoes ❑ Intermittently ❑ Morning ❑ Running

❑ Standing ❑ Walking

Cause: ❑ Unknown ❑ Developed gradually

❑ Injury: _____

Treatment: ❑ Compression ❑ Elevation ❑ Heat ❑ Ice

❑ Medication ❑ Rest ❑ Stretching ❑ Shoe Change

Ongoing Medical Conditions/ Past Medical History

❑ NONE ❑ Cancer ❑ Gout ❑ Lung Disease ❑ Seizure Disorders ❑ Anxiety ❑ Chemotherapy

❑ Heart Attack ❑ Lupus ❑ Sports Related Injury ❑ Arthritis ❑ Circulation Problems ❑ Heart Disease

❑ Neuropathy ❑ Stomach Ulcers ❑ Asthma ❑ Depression ❑ Hepatitis type: _____

❑ MRSA Infection ❑ Stroke ❑ Bleeding Disorder ❑ Diabetes (Insulin) ❑ Diabetes (non-Insulin)

❑ High Blood Pressure ❑ Osteoporosis ❑ Swelling in Legs/Feet ❑ Blood Clots ❑ Kidney Disease

❑ Pain in Legs/Feet/Toes ❑ Thyroid Disorders ❑ Callus Formation ❑ Foot Ulcerations ❑ Liver Disease

❑ RSD/CRPS ❑ Other: _____

Previous Surgeries

❑ NONE

❑ Amputation ❑ Angioplasty/stent ❑ Appendectomy ❑ Back/spine ❑ Blood Transfusion ❑ Bunion

❑ Carpal Tunnel ❑ Cataracts ❑ Gallbladder ❑ Gastric Bypass ❑ Hammer Toe ❑ Heart Bypass

❑ Heart Valve Replacement ❑ Hysterectomy ❑ Ingrown Nail ❑ Joint Replacement: _____

❑ Lap Band ❑ Lower Extremity Bypass ❑ Neuroma ❑ Pacemaker ❑ Tonsils

❑ Transplant: _____ ❑ Other: _____

Family Medical History

Biological Family	Mother	Father	Sibling	Grandparent
None	❑	❑	❑	❑
Cancer	❑	❑	❑	❑
Diabetes	❑	❑	❑	❑
Hypertension	❑	❑	❑	❑

Social History

Alcohol Consumption	Smoking
❑ None	❑ Never
❑ Occasional	❑ Former
❑ Daily	❑ Daily
	❑ Social

Review of Systems

Psychiatrics: ❑ 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: _____