

Foot & Ankle Specialists, P.C.

Dr. Scott E. Hughes

Dr. Greg P. Vogt

Dr. Christine I. Tumele

PATIENT INFORMATION

Patient Name _____ Date _____
Address _____ City _____ State ____ Zip ____
Birthdate _____ Age _____ Sex _____
Email to receive quarterly newsletter: _____
SS#(required): _____
Home Phone _____ Work Phone _____

We will use the information listed above to communicate with you. This includes leaving a detailed telephone message if needed. However, if you prefer a different form of communication, please indicate here:

Written Communication via email

address: _____

Oral Communication – leave message with callback number only

Occupation/Employer _____

Emergency contact _____

Relationship _____ Phone _____

How were you referred to our office? _____

Your Preferred pharmacy: _____

INSURANCE INFORMATION

Person responsible for this account _____

Birthdate _____ Social Security # _____

Relationship to patient _____

Primary Insurance _____

Secondary Ins. _____

Other Ins. _____

(Please make sure that we have made a copy of your insurance card(s))

TELL US ABOUT YOUR FEET

Please list all of your foot and/or ankle problems _____

Have you seen another Dr. for this problem? Who & When? _____

What do you think is causing your problem? _____

Do any foot problems run in your family (bunions, flat feet etc.). _____

Please list sports or exercise you participate in. _____

Have you ever had foot surgery before? What, where and when? _____

Foot & Ankle Specialists Patient Intake Form

Dr. Hughes

Dr. Vogt

Dr. Tumele

Patient Name _____ Date _____

Please fill out this form to the best of your knowledge. We can also assist you. This gives our doctors important information about your health. We are interested to learn about you and this helps us to help you. Thank you.

REVIEW OF SYSTEMS: Please check if you are experiencing any of the following:

Constitutional:

- Change in thirst or appetite
- Chills
- Fatigue
- Fever
- Weight change

Genitourinary:

- Frequent UTI's

Musculoskeletal:

- Uses an Assistive Device
- Back pain
- Feet & ankle swelling
- Joint pain
- Paralysis

Psychiatric:

- Chemical dependency
- Emotional problems
- Forgetfulness

Eyes:

- Eye or vision problems

Cardiovascular:

- Chest pain
- Cold feet
- Cold intolerance
- Heart palpitations
- Racing heart
- Slow heartbeat

Dermatologic:

- Rash
- Skin sores

Endocrine:

- Elevated liver enzymes

Hematologic:

- Bleeding tendency
- Cuts take long to heal
- Swollen lymph nodes

Ear/Nose/Throat/Neck:

- Difficulty hearing

Respiratory:

- Breathing difficulty
- Cough
- Shortness of breath

Gastro:

- Heartburn
- Nausea or vomiting

Neurologic:

- Numbness
- Tingling
- Weakness

LIST ALL SURGERIES, THE DATE AND DOCTOR: Please write on back if more room is needed

PAST MEDICAL HISTORY: Please check the items if you've EVER been diagnosed as having and CIRCLE the associated disease that follows. Please write in any diseases not mentioned below that you suffer from.

Abuse of: Alcohol, Narcotics, Cocaine, Heroin, Prescriptions

Anemia: Folate, Iron deficiency, Sickle cell, B12, Not sure

Angina: stable, unstable, Not sure

Anxiety disorder: PTSD, OCD, panic, Manic Depressive

Arthritis: DJD, Gout, Osteoarthritis, Joint Replacement surgeries (list below in surgery section)

Asthma: Mild, Moderate, Severe

Autoimmune Arthritis: Lupus, MCTD, Scleroderma, Rheumatoid Arthritis, JRA, Psoriatic Arthritis

Back Injury: Fracture, Disc herniation, Sprain, Previous Back Surgery

Back Pain: Disc Disease, Sciatica, Arthritis, Previous Back Surgery

Bleeding Disorder: Platelet dysfunction, Blood thinner medication, bruise easily

Bowel Problems: Inflammatory Bowel Dz, Chron's, IBS, Ulcerative Colitis, Colostomy

Broken Bone: Hand, Foot, Ankle, Leg, Arm, Hip, Shoulder, Neck, Back

Cancer: Brain, Thyroid, Leukemia, Metastasis, Liver, Kidney, Lung

- __ **Cancerous Tumors:** Breast, Cervical, Ovarian, Uterine, Prostate, Melanoma, Colon, Skin
- __ **Cardiac Arrhythmia:** Atrial fibrillation, Slow or Fast heartbeat, Pacemaker, Tachycardia, PVCs
- __ **Circulation problems:** in hands, in legs, in feet,
- __ **Dementia:** Alzheimer's, Alcoholic, Senile, Memory Loss
- __ **Diabetes:** Pregnancy onset, Juvenile, Adult onset, Diet controlled, Controlled, Poor control
- __ **Ear problems:** Infection, Hearing Loss, Ringing
- __ **Eye problems:** Glaucoma, Macular Degeneration, Retinopathy, Blindness
- __ **Headaches:** Tension, Stress, Migraine
- __ **Heart Condition:** Mitral valve prolapse, Valve Replacement, Heart Attack, Congestive Heart Failure, Murmur, Coronary artery disease
- __ **Hepatitis:** A, B, C, Not sure
- __ **HIV or AIDS**
- __ **High Blood Pressure:** Controlled, Uncontrolled
- __ **Kidney Disease:** Dialysis, Failure, Insufficiency, Infections, Arterial Stenosis
- __ **Liver Disease:** Cirrhosis, Fatty, Ascites
- __ **Menopause**
- __ **Neurologic Disease:** Multiple Sclerosis, Polio, Parkinson's Disease, Neuropathy, RSD
- __ **Venous Blood Clot or Phlebitis:** superficial, deep, arm, leg, lung
- __ **Pinched Nerves:** Sciatica right leg, Sciatica left leg, Carpal Tunnel Syndrome
- __ **Psychiatric Care:** Depression, ADD, Bipolar, Delusional, Stress
- __ **Rash:** Eczema, Psoriasis
- __ **Reynaud's Syndrome**
- __ **Respiratory Condition:** History of Smoking, COPD, Bronchitis
- __ **Rheumatic Fever**
- __ **Seizure Disorder:** Epilepsy, Grand Mal, Focal, Partial
- __ **Sinus Conditions:** Seasonal Allergies, Infection, Sinusitis
- __ **Stomach Problems:** GERD, Diverticulitis, Constipation, Diarrhea, Polyps, Ulcers
- __ **Stroke:** TIA, CVA
- __ **Tuberculosis or TB:** active infection, carrier, treated, positive test without active infection
- __ **Thyroid disorder:** Hyperthyroidism, Hypothyroidism
- __ **Ulcers:** Legs, Feet
- __ **Other Diseases:** _____

FAMILY HISTORY:

Mother:	<input type="checkbox"/> Heart problems	<input type="checkbox"/> Cancer	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Arthritis	_____
Father:	<input type="checkbox"/> Heart problems	<input type="checkbox"/> Cancer	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Arthritis	_____
Sisters:	<input type="checkbox"/> Heart problems	<input type="checkbox"/> Cancer	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Arthritis	_____
Brothers:	<input type="checkbox"/> Heart problems	<input type="checkbox"/> Cancer	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Arthritis	_____
Children:	<input type="checkbox"/> Heart problems	<input type="checkbox"/> Cancer	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Arthritis	_____

SOCIAL HISTORY: Circle the proper answers for you

ALCOHOL USE:

I drink alcohol: Never, 1 time weekly / 3 times a week / Daily, Special Occasions / I am a Recovering Alcoholic

DIET:

I eat a: Regular diet / Fast Food / Low Fat / Low Salt / Low Sugar / Weight Loss Diet

EMPLOYMENT:

My Employment requires: Prolonged Standing / Prolonged Walking / Prolonged Sitting / other _____

EXERCISE:

I exercise: 1-3 times a week / more than 4 times a week, by _____
 Sports I participate in: _____

DRUG HISTORY:

I use these illegal drugs: Never / cocaine / heroin / narcotics / other _____

SMOKING HISTORY

I do not smoke
 I smoke _____ packs of cigarettes every _____ day(s) for _____ of years.
 I quit smoking, How long ago _____. I used to smoke _____ packs per day for _____ years

MEDICATIONS: Please LIST ALL NONPRESCRIPTION AND PRESCRIPTION MEDICATIONS, vitamins and herbs you take (include injections at home or from a doctor's office). We can make a photocopy of your medications list.

ALLERGIES: Please list Allergies and types of Allergic Reactions.

<input type="checkbox"/> Adhesive tape	<input type="checkbox"/> Demerol	<input type="checkbox"/> Novocain	Other: _____
<input type="checkbox"/> Anticoagulants	<input type="checkbox"/> Eggs	<input type="checkbox"/> Peanuts	_____
<input type="checkbox"/> Aspirin	<input type="checkbox"/> Iodine	<input type="checkbox"/> Penicillin	_____
<input type="checkbox"/> Cipro	<input type="checkbox"/> IVP Dye	<input type="checkbox"/> Seafood	
<input type="checkbox"/> Codeine	<input type="checkbox"/> Latex	<input type="checkbox"/> Sulfa	

Are you Pregnant?: Yes / No / Not sure. Expected Due Date: _____

Name of Family Physician _____

Phone Number of Physician _____

Most Recent Date of Physical Exam _____

Are you currently under the care of this doctor: Yes, No.

If yes, please state the reason _____

This form has been filled out to the best of my knowledge. I understand that any omissions may jeopardize my health and I cannot hold Foot & Ankle Specialists, P.C. responsible for any misinformation that I supplied.

Signature of patient _____ Date _____

Thank you

We welcome you to our practice. We are happy you chose our office for your foot and ankle treatment.. We will strive to make your experience as pleasant as possible. We will always try to answer your questions. Please feel free to give us any feedback. A referral of your friends or family is our greatest compliment.

FAS initials _____ Date _____

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AUTHORIZATION FOR TREATMENT AND INSURANCE PAYMENT

Patient Name _____ Birthdate _____

ASSIGNMENT AND RELEASE

- I, the undersigned certify that I (or my dependant) have insurance coverage with:

- I assign directly to Foot & Ankle Specialists, PC all insurance benefits, if any, otherwise payable to me for services rendered.
- I understand that ultimately, I am financially responsible for all charges whether or not they are paid by insurance.
- I hereby authorize the Foot & Ankle Specialists, PC to release all information necessary to secure the payment of benefits.
- I authorize the use of this signature or its copy on all insurance submissions.

Patient Signature _____ Date _____

Parent or authorized Rep _____

Relationship to insured _____

MEDICARE AUTHORIZATION (For Medicare or Medicare HMO patients only)

- I authorize payment to be made on my behalf to Foot & Ankle Specialists, PC.
- Information to process a claim on my behalf may be released to my insurance company.
- I am responsible for my 20% co-pay and yearly deductible for covered services.
- I will be notified prior to treatment if services are not covered by Medicare.

Beneficiary
Signature _____ Date _____

AUTHORIZATION FOR TREATMENT

I certify that the information I have provided concerning my health and medical history is complete, true and correct to the best of my knowledge. I give permission to the doctors of Foot & Ankle Specialists, PC to administer and perform services and/or procedures as may be deemed necessary in the diagnosis and treatment of my feet, ankles or hands.

Signature _____ Date _____

**ACKNOWLEDGMENT OF RECEIPT
OF
NOTICE OF PRIVACY PRACTICES
FOR
FOOT & ANKLE SPECIALISTS, PC**

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read if I so chose) and understood the Notice.

Patient Name (please print)

Date

Parent or Authorized Representative (if applicable)

I permit Foot & Ankle Specialists, P.C. to discuss my Private Health Information (PHI) with, and to disclose my PHI to, the following individuals:

___ Spouse _____

___ Adult Child(ren) _____

___ My parent(s) _____

___ Other _____

Signature

OFFICE POLICY AGREEMENT

INITIAL REGISTRATION AND UPDATES

Please fill out the registration forms as completely as possible. Be sure to read and sign the "consent for treatment" section. If there is ever a change in your name, health insurance, address or phone number, please notify our front desk. Your medical history will be reviewed and updated as needed at each appointment.

INSURANCE

Present your insurance card to our receptionist at your first appointment, we must have complete and accurate information to file your claim for you. Benefits will be verified through your insurance carrier prior to being seen by the doctor.

Please be aware that you have final responsibility for payment of services rendered. Any amount not covered or not paid by your insurer will be billed to you directly.

PAYMENT AT TIME OF SERVICE

Payment for all deductibles, copayments and non-covered services is due at the time of treatment, unless previous arrangements have been made with our billing department. For your convenience, we accept cash, personal checks, Mastercard, Visa and Discover. There is a \$30 fee for checks returned by your bank.

COLLECTION POLICY

Statements will be sent monthly for any balance due on your account. If no extended payment arrangements have been made, we expect full payment for services rendered within 15 days. There is a \$5.00 rebilling fee that will be assessed to all accounts past due.

If an account balance has not been paid in full within 90 days, no additional appointments will be scheduled until the balance is paid. Accounts may then be referred to a collection agency. You will be responsible for any collection and/or court costs incurred during the collection process.

The responsibility for payment of services rendered to dependent children rests with the parent who seeks treatment for the child. Any court ordered responsibility judgment must be handled between the individuals involved, without the inclusion of our office.

APPOINTMENT POLICY

As a courtesy, our office will attempt to contact you the day before your scheduled appointment. However, the responsibility for keeping appointments is yours. If it is necessary to reschedule an appointment, please give us as much notice as is possible so we can schedule another patient during that time.

It is our hope that the above office policies will allow us to provide quality care to our valued patients. If you have any questions or need clarification of any of these policies, please do not hesitate to ask.

My signature below indicated that I have read the statements above, understand, and agree to comply with this policy.

Patient Signature

Date