

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 _____ Email _____
Birthdate _____ Age _____ Sex _____ SS#: _____
Home Phone _____ Work Phone _____
Occupation/Employer _____
Emergency contact _____
Relationship _____ Phone _____
How were you referred to our office? _____

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)- Thank You)

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 the problems you've recently had

- | | | |
|---|---|---|
| <input type="checkbox"/> Uses an Assistive Device | <input type="checkbox"/> Difficulty hearing | <input type="checkbox"/> Nausea or vomiting |
| <input type="checkbox"/> Back pain | <input type="checkbox"/> Elevated liver enzymes | <input type="checkbox"/> Numbness |
| <input type="checkbox"/> Bleeding tendency | <input type="checkbox"/> Emotional problems | <input type="checkbox"/> Paralysis |
| <input type="checkbox"/> Breathing difficulty | <input type="checkbox"/> Eye or vision problems | <input type="checkbox"/> Racing heart beat |
| <input type="checkbox"/> Change in thirst or appetite | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Rash |
| <input type="checkbox"/> Chest pain | <input type="checkbox"/> Feet & ankle swelling | <input type="checkbox"/> Shortness of breath |
| <input type="checkbox"/> Chemical dependency | <input type="checkbox"/> Fever | <input type="checkbox"/> Skin sores |
| <input type="checkbox"/> Chills | <input type="checkbox"/> Forgetfulness | <input type="checkbox"/> Slow heartbeat |
| <input type="checkbox"/> Cold feet | <input type="checkbox"/> Frequent UTI's | <input type="checkbox"/> Swollen neck lymph nodes |
| <input type="checkbox"/> Cold intolerance | <input type="checkbox"/> Heart palpitations | <input type="checkbox"/> Tingling |
| <input type="checkbox"/> Cough | <input type="checkbox"/> Heartburn | <input type="checkbox"/> Weakness |
| <input type="checkbox"/> Cuts take long to heal | <input type="checkbox"/> Joint pain | <input type="checkbox"/> Weight change |

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 _____

Foot & Ankle Specialists, P.C.

Dr. Scott E. Hughes Dr. Gregory P. Vogt Dr. Christine I. Tumele

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)

Signature