



PATIENT INFORMATION

DATE _____ PHARMACY/LOCATION _____ PCP _____

PATIENT NAME _____ SEX _____ AGE _____ DATE OF BIRTH _____ / _____ / _____

ADDRESS _____ HOME PHONE _____

CITY/STATE _____ ZIP _____

E-MAIL ADDRESS _____ MOBILE PHONE _____

RACE _____ ETHNICITY _____ PRIMARY LANGUAGE _____ MARITAL STATUS: _____

PATIENT'S EMPLOYER NAME & ADDRESS _____

OCCUPATION _____ BUSINESS PHONE _____

IN CASE OF AN EMERGENCY WHOM MAY WE CONTACT _____

PHONE _____ RELATIONSHIP _____

HOW WERE YOU REFERRED TO OUR OFFICE _____

WHO IS THE RESPONSIBLE PARTY (IF THE PATIENT IS A MINOR OR STUDENT) _____

ADDRESS _____

SUBSCRIBER (INSURANCE HOLDER'S) NAME _____ DOB _____ / _____ / _____

INSURED'S EMPLOYER NAME & ADDRESS _____

PHONE NUMBER _____ RELATIONSHIP TO PATIENT _____

IS THIS VISIT DUE TO A WORK-RELATED INJURY? YES NO

WORKERS COMP. CARRIER NAME _____

DOES YOUR INSURANCE REQUIRE PRIOR AUTHORIZATION/REFERRAL YES NO

(I understand that I am financially liable for all costs incurred for all visits if my insurance requires a referral and I fail to obtain one.)

PLEASE READ CAREFULLY AND SIGN:

SIGNATURE ON FILE

I request that payment of authorized benefits be made either to me or on my behalf to Advanced Foot and Ankle Specialists for any services furnished to me by that physician / supplier. I authorize any holder of medical information about me to release to CMS and its agents, or any other supplier of medical benefits, any information needed to determine those benefits, or the benefits for related services.

I understand that regardless of any insurance coverage that I may have, it is my responsibility to pay my bill. I understand that I am responsible for my bill if my insurance does not pay because I failed to obtain a referral if one was required. I further understand that my insurance is designed to reimburse Advanced Foot and Ankle Specialists for covered expenses. I understand further that not all services are covered by Medicare or other insurance plans and acknowledge that I am responsible and will pay for those services. I agree to pay all costs of collection, including a reasonable attorney's fee, incurred in the collection of any amounts not paid, as required above.

(PATIENT OR RESPONSIBLE PARTY)

Patient Name: _____ Patient DOB: _____

Review of Systems — Check the conditions/diseases you have now or have had in the past:

<input type="checkbox"/> Abnormal ECG	<input type="checkbox"/> Cirrhosis	<input type="checkbox"/> High Cholesterol	<input type="checkbox"/> Pacemaker Hx
<input type="checkbox"/> Alcoholism	<input type="checkbox"/> Clotting Disorder	<input type="checkbox"/> HIV disease/risk	<input type="checkbox"/> Psoriasis
<input type="checkbox"/> Allergies	<input type="checkbox"/> COPD	<input type="checkbox"/> Hypertension	<input type="checkbox"/> Psychiatric Disorder
<input type="checkbox"/> Anemia	<input type="checkbox"/> Deep Vein Thrombosis	<input type="checkbox"/> Keloid	<input type="checkbox"/> Rheumatoid Arthritis
<input type="checkbox"/> Anxiety	<input type="checkbox"/> Diabetes Mellitus Type 1 or Type 2	<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Seizures
<input type="checkbox"/> Asthma	<input type="checkbox"/> Diverticulitis	<input type="checkbox"/> Leg Swelling	<input type="checkbox"/> Sickle Cell Anemia
<input type="checkbox"/> bleeding Disorder	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Liver Disease	<input type="checkbox"/> Skin Ulcer
<input type="checkbox"/> bronchitis (frequent)	<input type="checkbox"/> Gestation Diabetes	<input type="checkbox"/> Lower Extremity Swelling	<input type="checkbox"/> Stomach Ulcer
<input type="checkbox"/> CAD	<input type="checkbox"/> Gout	<input type="checkbox"/> Lyme Disease	<input type="checkbox"/> Stroke
<input type="checkbox"/> Cancer	<input type="checkbox"/> Hepatitis A B C	<input type="checkbox"/> Myocardial Infarction	<input type="checkbox"/> Substance Abuse
<input type="checkbox"/> Cerebral Palsy	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Osteoporosis	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> CHF		<input type="checkbox"/> MS	<input type="checkbox"/> Other _____

List your medications: _____

List your allergies to medications or substances: _____

MEDICAL AND SOCIAL HISTORY

Have you ever had surgery? Yes No If Yes, what kind and when? _____

Did you have any complications related to your surgery? Yes No If Yes, describe: _____

Circle all that apply:

Tobacco use? Cigarettes Cigars Smokeless/Chewing tobacco If so, how much? _____

Alcohol use? Current Previous Drinks per day? _____ What kind? _____ Last used? _____

Illegal drug use? Injection Oral Smoking What kind? _____ Last used? _____

Last day of Work (If Applicable) _____

FAMILY HISTORY

Circle all of the diseases and conditions below that run in your family:

Heart disease Rheumatoid Arthritis Bleeding Disorders Cancer Diabetes Other _____

Bleeding Disorders Connective Tissue Disorders Muscular Dystrophy Hypertension Other _____

Patient Name: _____ Patient Signature: _____ Date: _____

TO BE COMPLETED BY DOCTOR

☐ All systems reviewed and negative.

☐ All systems reviewed with the following findings: _____

Doctor's signature: _____

Date of visit: _____



CREDIT CARD ON FILE POLICY

At Advanced Foot and Ankle Specialists, we require your credit or debit card on file as a convenient method of payment for the portion of services that your insurance doesn't cover, but for which you are responsible.

Please be advised that this card will be charged \$50.00 in the event of a "no show" (cancellation within 24 hours of an apt is considered a "no show").

Your credit card information is kept confidential and secure and payments to your card are processed only after the claim has been filed and processed by your insurer, and the insurance portion of the claim has been paid and posted to the account.

Any outstanding balance over 90 days, with no attempt to make a payment, will be charged to the card listed below in accordance with the office consent and acknowledgment agreement.

I authorize Advanced Foot and Ankle Specialists to charge the portion of my bill that is my financial responsibility to the following credit or debit card:

☐ Amex ☐ Visa ☐ Mastercard ☐ Discover

Credit Card Number _____

Expiration Date ____ / ____ / ____

Cardholder Name _____

Signature _____

Billing Address _____

City _____ State _____ Zip _____

I (we), the undersigned, authorize and request Advanced Foot and Ankle Specialists to charge my credit card, indicated above, for balances due for services rendered that my insurance company identifies as my financial responsibility.

This authorization relates to all payments not covered by my insurance company for services provided to me by Advanced Foot and Ankle Specialists.

This authorization will remain in effect until I (we) cancel this authorization. To cancel, I (we) must give a 60 day notification to Advanced Foot and Ankle Specialists in writing and the account must be in good standing.

Patient Name (Print): _____

Patient Signature: _____

Date: ____ / ____ / ____