First Name_____ Middle_____ Last_____

SEX: Male Female Unknown DOB:____/____/_____

SS #:_____-_____-_____ Marital Status: Married Single Divorced Widow (er)

CONTACT INFORMATION:

Cell Phone:_____-_____-_____ E-Mail Address:_____
No Cell Phone ☐ No Email: ☐

Home Phone:_____-_____-_____ Work Phone:_____-_____-_____ EX_____

Address:_____ City_____ State____ Zip_____

☐ My practice has documented that this patient has provided their prior express consent to receive automated texts and voice messages at the number(s) provided above.

PAYMENT INFORMATION: Primary Secondary Self-Pay (Circle those that apply)

Primary Ins:_____ Grp #:_____ ID #:_____ Eff Date_____

Secondary Ins:_____ Grp #:_____ ID #: _____ Eff Date__

GUARANATOR: Relationship to Patient: _____

First Name_____ Middle_____ Last_____

DOB:____/____/_____ SEX: Male Female Unknown SS#_____-_____-_____

Primary Phone #:____-____-_____ EX_____ Secondary Phone #: _____-_____-_____ EX_____

PHARMACY:

Name_____ Address_____ City_____ Zip_____

Phone #:_____-_____-_____ FAX # _____-_____-_____

Primary Care Physician (PCP):_____ Phone #:_____-_____-_____

Were you referred to us by a physician? Physician's Name:_____

Were you referred to us by one of our patients? Patient's Name_____

EMERGENCY CONTACT: First Name: _____Last:_____

Relationship to Patient: _____

Address:_____ City_____ State_____ Zip_____

Home Phone #: _____ Cell #: _____Work #: _____

Last Name: _____ First: _____ DOB: _____

What is your primary foot/ankle complaint today? _____

What treatments have you tried for this problem? _____

_____

Diabetic? Yes ☐ Type 1 ☐ Type 2 ☐ Insulin? Yes No Avg Blood Sugar Reading: _____

PAST MEDICAL HISTORY/SURGERIES: _____

_____

ONGOING MEDICAL PROBLEMS-Please check all that you currently have or have experienced in the past

- ☐ Allergies
- ☐ Alzheimers / Dementia
- ☐ Anemia
- ☐ Anesthesia Complications
- ☐ Arthritis: Type_____
- ☐ Asthma / COPD
- ☐ Blood Clots
- ☐ Cancer
- ☐ Cholesterol Elevated
- ☐ Circulatory Problems
- ☐ Diabetes
- ☐ Dropfoot
- ☐ Fibromyalgia
- ☐ GERD / Reflux
- ☐ Gout
- ☐ Heart Disease/Heart Attack
- ☐ HIV / AIDS
- ☐ Hypertension
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Lyme Disease
- ☐ Macular Degenration
- ☐ Multiple Sclerosis
- ☐ Panic Disorder / Depression
- ☐ Parkinson's Disease
- ☐ Psoriasis
- ☐ Seizures / Epilepsy
- ☐ Sickle Cell
- ☐ Skin Ulcer
- ☐ Stroke / TIA
- ☐ Neuropathy
- ☐ Bunions
- ☐ Calluses
- ☐ Ingrown Toenails
- ☐ Hammertoes
- ☐ Other (List Below)

_____

_____

_____

CURRENT MEDICATIONS: _____

_____

_____

_____

_____

ALLERGIES & REACTIONS:

METAL? Yes ☐ No ☐ _____ CONTRAST DYE? Yes ☐ No ☐ _____ Drug Allergies? Yes ☐ No ☐ Unknown

LATEX? Yes ☐ No ☐ _____ IODINE? Yes ☐ No ☐ _____ _____

TAPE? Yes ☐ No ☐ _____ SHELLFISH? Yes ☐ No ☐ _____ _____

SOCIAL HISTORY:

Smoke? Yes ☐ No ☐ How many packs per day? _____ How many years? _____

Alcohol? Yes ☐ No ☐ What type of alcohol? _____ How many per day? _____

Drug Use? Yes ☐ No ☐ What type? _____

FAMILY HISTORY: Please check conditions which have affected your FAMILY (parents/siblings).

- ☐ Arthritis (Type)_____
- ☐ Cancer (Type)_____
- ☐ Diabetes (Type)_____
- ☐ Heart Disease
- ☐ High Blood Pressure
- ☐ Sickle Cell
- ☐ Bunions
- ☐ Hammertoes
- ☐ Flat Feet

Other: _____

REVIEW OF CURRENT SYSTEMS: Please circle all that apply

EYES: Contacts Glasses Reading Glasses Blurred Vision Eye Pain/Disease Floaters
Vision Change Double Vision
None apply

HEAD/ENT: Headaches Migraines Vertigo Lightheadedness Hearing Loss Ringing in Ears
Hearing Aids Nasal Congestion. Nose Bleeds Sinus Problems Sore Throat
Difficulty Swallowing Swollen Glands
None Apply

CARDIOVASCULAR: Chest Pain Pacemaker Cardiac Arrest Claudication Lower Extremity
Palpitations Stents
None Apply

RESPIRATORY: Shortness of Breath Cough Wheezing Pain w/ Breathing Difficulty Breathing
None Apply

GASROINTESTINAL: Heartburn Diarrhea Constipation Nausea Vomiting Loss of Appetite
Eating Disorder Abdominal Pain Rectal Bleeding
None Apply

GENITOURINARY: Pain / Bleeding or Difficulty Urinating Kidney Stones None Apply
None Apply

ENDOCRINE: Dry Skin Nail Changes Hives Pressure Ulcers Itch Rash Varicose Veins
Heat/Cold Intolerance
None Apply

NEUROLOGIC: Sciatica Numbness Tingling/Burning in Feet Dizziness Poor Balance
None Apply

MUSCULOSKELETAL: Joint Pain Joint Swelling Muscle Pain Difficulty Walking Back Pain
Muscle Pain/Cramps Difficulty Walking Weakness of Joints/Muscles
None Apply

PSYCHIATRIC: Depression Difficulty Sleeping Anxiety None Apply

HEMATOLOGICAL: Easy Bleeding Easy Bruising Anemia Past Transfusions Blood Clots
None Apply

List any specialists currently being seen._____
_____

PRIVACY POLICY:

To ensure your privacy, please answer the following and notify the Front Office if this information changes:

1. Do we have permission to leave a message on the phone numbers provided? ☐ Yes ☐ No
2. May we leave results of testing on the number provided? ☐ Yes ☐ No
3. May we discuss your medical information with designated family and/or friends? ☐ Yes ☐ No

Please list the names of those we can discuss your medical care with:

Name:_____ Phone #:_____ Relation:_____

Name:_____ Phone #:_____ Relation:_____

FINANCIAL POLICY:

1. Insurance is a contract between you and your insurance company. We will bill your primary insurance as a courtesy. In order to do this, you must disclose all insurance information including primary and secondary insurance and keep our office updated on any and all changes in your insurance coverage. Failure to provide accurate information may result you being financially responsible for the entire bill.

Although we may estimate what your insurance company will pay for treatment, it is your insurance company that makes the final decision regarding your benefits and eligibility. You will be financially responsible for all bills not paid by your insurance.

2. Certain insurance plans require that you obtain a referral and/or a prior authorization from your Primary Care before visiting a specialist. It is your responsibility to obtain these documents, if necessary, and provide them to our office before your scheduled appointment. If required and not received by our office before your appointment, you will be considered "self-pay" with full payment due at the time of service.

3. Fees for services, which include unpaid balances, deductibles, co-pays, co-insurance and non-covered fees are due at the time of service. Appointments will not be made for those with outstanding balances. Failure to pay unpaid balances in a timely manner will result in a referral to a collection agency.

4. There will be a charge of $35 for returned checks. This fee may be paid by cash or money order. If unpaid, this fee will be added to your account and may result in your account being placed on a cash basis only. Unpaid check fees and balances are subject to collection placement.

5. Completion of Forms, copies of Medical Records, X-Rays and Reports are not billable through your insurance company. There will be a $15 fee for providing these services.

6. There will be a $15 fee for late or missed appointments. For this reason, no future appointments will be scheduled if patient has outstanding balance.

7. I have had the opportunity to read my HIPAA Privacy Policy and understand a copy will be provided to me at my request.

I UNDERSTAND THE ABOVE INFORMATION AND AGREE TO BE FINANCIALLY RESPONSIBLE FOR THE PATIENT LISTED BELOW.

Print Name of Patient_____ DOB: _____

Print Name of Financially Responsible Party _____ Phone #:_____

Signature of Patient or Responsible Party_____ Date: _____

DISCLAIMER

Physician "Referrals"
vs
Insurance "Authorization"

Primary Care Physicians (PCP's) often "refer" their patients to specialists for further treatment. This referral does not guarantee the insurance company will pay for that treatment. Some insurance plans also require "prior authorization" to insure visits to a specialist will be covered.

The Referral Coordinator in your PCP's office can tell you if your plan requires this authorization and can assist you in obtaining it. If required, Chateau Foot and Ankle must have this authorization prior to your appointment.

Patients with Medicare as their primary insurance do not have to obtain authorization for medically necessary treatment. Medicare Advantage Plans differ and some may require prior authorization. Cigna Health Springs Plan is one that requires an authorization.

I understand it is my responsibility to contact my PCP's office to determine if I need prior authorization from my insurance company. If so, my PCP's office can FAX that authorization to: 706-780-5366.

I also agree to pay Chateau Foot and Ankle for any fees not covered or denied by my insurance company.

_____ _____

Patient Name (Please Print) Patient Signature

_____

Date