Littleton Foot and Ankle Clinic

Patient information (PLEASE PRINT)

Patient Full Name: _____ Date: _____
First Middle Initial Last
DOB: _____ Sex: M / F Social Security Number: _____-_____-_____
Race: (*please circle)* American Indian/Alaska Native Asian Black/African American White Other Decline
Ethnicity: *(please circle)* Hispanic/Latino NOT Hispanic or Latino Decline
Marital Status: [ ] Married [ ] Single [ ] Widowed [ ] Divorced [ ] Separated
Address: _____
City: _____ State: _____ Zip: _____
Home Phone: _____ Work: _____ Cell: _____
Email address* (we will never share your email address with anyone): _____
*Email will not be used for any personal medical identifying information.
Preferred method of communication *(please circle):* Home phone Work phone Cell phone E-mail
Employment status: [ ] Employed [ ] Unemployed [ ] Retired [ ] Disabled [ ] Student
Employer: _____ Occupation: _____
Spouse name: _____
Spouse's employer: _____DOB: _____ SSN: _____

Emergency contact information

Emergency contact name: _____
Contact phone # ( ) _____ Relationship: _____

Billing & Insurance Information

Primary Insurance Name: _____
Policy # _____ Group # _____
Policy holder name/Guarantor: _____SSN _____ DOB _____
Address: _____
Secondary Insurance Name: _____
Policy # _____ Group # _____
Policy holder name/Guarantor: _____ SSN _____ DOB _____
Address: _____

Pharmacy Information

Pharmacy Name: _____ Phone # _____
Pharmacy Address: _____

Referral Information *Whom may we thank for referring you to our office?*
Name: _____ Address: _____
Is this person your: *(please circle)* PCP Other specialist Family Member Friend Previous patient Other _____
Other referral sources *(please circle)* Internet search (Google/other) Yellow pages/Dexonline Insurance Website Mailer

Patient full name: _____ DOB: _____

Name of Primary Care Physician: _____ Date of last visit: _____
Address: _____ Phone: _____
Are you now, or have you been under any other doctor's care for any reason in the last two years? Yes No
If yes, please explain: _____

PODIATRIC HISTORY

Have you ever been to a Podiatrist before? Yes No

What is your **main foot or ankle complaint** for which you are seeking treatment? _____
_____

When did it begin? _____

Have you received treatment for this condition? Yes No; If so, what was done? _____
_____

Does this problem interfere with your activities? Yes No; Please explain: _____
_____

Circle the degree of pain you are experiencing: Minimal 1 2 3 4 5 6 7 8 9 10

What is your shoe size? _____ Narrow Medium Wide

MEDICAL HISTORY

Surgeries/Hospitalizations

Surgery/Hosp	Date

MEDICATIONS

You can provide a list of your medications or list below (**Please Print**)

Name	Strength/mg	Take how often?

Are you currently taking blood thinners? Yes No

SOCIAL HISTORY

Do you currently use cigarettes or tobacco? Yes No; # years smoked _____ How many packs/day? _____
If quit, what year? _____

Alcohol use? Yes No; If yes, quantity _____ per day _____ per week _____ per month _____ per glass
Please circle: Beer Wine Other

Do you participate in any exercise or physical activity on a regular basis? Yes No
If so, what type: _____ Intense of exercise: Light Moderate Vigorous

Duration of exercise: _____ Min _____ Hours; Frequency: Daily Weekly Monthly Other_____

Have you ever experienced any of the following?

Please check all that apply:

____ Ankle Instability
____Arthritis
____Back pain
____Blisters
____Bone spurs
____Bunions
____Burning feet
____Corns/calluses
____Flat feet
____Foot infection
____Fracture
____Fungal infection
____Tendonitis
____Tired feet
____Ulcers/wounds
____Warts
____Hip pain
____Ingrown toenails
____In/out toe walking
____Knee pain
____Limb length inequal
____Neuromas
____Numbness/tingling
____Plantar fasciitis
____Shin splints
____Sprains
____Sweating/odor
____Fungal toenails
____Gout
____Hammertoes
____Heel pain

FAMILY HISTORY

Please check all that apply Relationship to you:

___Heart disease	
___Diabetes	
___Cancer	
___Other: _____	

ALLERGIES Yes / No

If yes, please check all that apply

Adhesive Tape		Metal/jewelry	
Anticoagulants		Lidocaine/novocaine	
Anti-inflammatories		Peanuts	
Aspirin		Penicillin	
Codeine		Seafood	
Cortisone		Sulfa	
Iodine		Tylenol	
Latex		Motrin/ibuprofen	
Other: _____			

Patient full name: _____ DOB: _____
What is your current height? _____ Current weight: _____

Have you been treated for any of the following conditions? Please check all that apply:

__Acid reflux
__Alcoholism
__Allergies
__Alzheimer's disease
__Anemia
__Arthritis
__Asthma
__Back problems
__Bleeding disorders
__Blood clots/DVT/PE
__Cancer
__Circulatory problems
__Congestive heart failure/CHF
__Depression
__Drug or chemical dependency
__Ear problems
__Eye problems
__Fibromyalgia
__Headaches
__Heart condition
__Hepatitis
__High Blood Pressure
__HIV/AIDS
__High cholesterol/LDL_____ Date of test: _____
__Diabetes/A1C_____ Date of test _____

__ Low blood pressure
__ Hyperthyroidism
__ Hypothyroidism
__ Kidney/bladder problems
__ Liver Disease
__ Medical Implants
__Nerve System disorder
__ Osteoporosis/osteopenia
__ Peripheral vascular/arterial disease
__ Parkinson's Disease
__ Psychiatric care
__ Respiratory disease
__ Rheumatic fever
__ Seizure disorders/epilepsy
__ Sinus problems
__ Sleep Apnea
__ Stomach Ulcers
__ Stroke
__ Tuberculosis/TB
__ Varicose veins
__ Vertigo
__ Other: _____

INFECTIONS
___ MRSA
__Hepatitis B
___Hepatitis C

I certify that the above information is true and correct to the best of my knowledge. I give my permission to Littleton Foot and Ankle Clinic, LLC and any qualified staff to administer and perform such procedures as may be deemed necessary in the diagnosis and/or treatment of my feet.

Patient Signature: _____ Date: _____

Release of Information

I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This information may be released to:

( ) Spouse _____
( ) Child(ren) _____
( ) Other _____
( ) Information is not to be released to anyone

( ) I Authorize Email for appointment reminders ( ) I DO NOT authorize email for appointment reminders

Patient Signature: _____ Date: _____

Financial Policy

Thank you for choosing our practice! We are committed to providing you with quality podiatric care. We have developed this payment policy to assist you in understanding our financial practices. Please read it carefully and sign in the space provided below.

Insurance

We participate with most insurance plans. If you do not have insurance or we do not participate in your insurance plan, payment in full is expected at each visit. Your insurance benefit is a contract between you and your insurance company. Knowing your insurance benefits is your responsibility but we will help explain your podiatric benefits so you can understand them.

We will keep a copy of your insurance card in your record, but you must notify us immediately if there has been any change. If you fail to inform us of updated insurance information, the balance on unpaid claims will become your responsibility. The Co-Pay is due at each visit. Co-Insurance, and deductibles are your responsibility and we may ask for pre-payment.

I certify that I have insurance with _____

Name of insurance company

and assign directly to Littleton Foot and Ankle Clinic, LLC all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.
Littleton Foot and Ankle Clinic may use my health care information and disclose such information to the above named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.
I request that payment authorized Medicare/Medicaid/Private insurance benefits, and, if applicable, Medigap benefits be made either to me or on my behalf Littleton Foot and Ankle Clinic for any services rendered to me by that provider.
To the extent of the law, I authorize any holder of medical or other information about me to release to the Center for Medicare and Medicaid services, my Medigap insurer, and their agents any information needed to determine these benefits or benefits for related services.

Non-covered Services

Please be aware that some of the services you receive may be non-covered by your insurance carrier. These services must be paid for at the time of visit.

Claims Submission

We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request promptly.

Payment

For your convenience, we accept cash, checks, VISA, MasterCard, and Discover. We reserve the right to refer your account to a collection agency if your account is over 90 days past due. Any collection fees, court costs, reasonable attorney fees, or returned check fees are the responsibility of the adult person(s) named on the delinquent account. Monthly service fee of 1.5% per month or 18% per annum will be assessed on all past due accounts.

Thank you for understanding our financial policy. Please let us know if you have any questions.

I have read and understand the financial policy and agree to abide by its guidelines.

Signature: _____ Date: _____

Notice of Privacy Practices

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our Main Phone Number. (Copy Available at Front Desk) **PLEASE NOTE THAT DUE TO HIPPA REGULATIONS IT IS OUR POLICY TO NOT ALLOW ANY TYPE OF VIDEO RECORDING OF PROCEDURES.**

Signature: _____ Date: _____