PATIENT INFORMATION

Please Print

☐ New Patient ☐ Established Patient

Name _____ Date of Birth ____/____/____
First Middle Last

☐ Male ☐ Female ☐ Married ☐ Single ☐ Widowed ☐ Divorced/Separated

Mailing Address: _____ Apt # _____

_____
City State Zip

Home Phone: _____ Work Phone: _____ Cell Phone: _____

SS# ____-____-_____ Employer: _____ Occupation: _____

Primary Care Physician: _____ Last Seen: _____

Referring Physician: _____ Last Seen: _____

If patient is a child/dependent adult, please give name of responsible party for finances and billing:

Responsible Party: _____ DOB: ____/____/____
(include relationship)

Home Address: _____ Apt # _____

_____
City State Zip

SS# ____-____-_____ Employer: _____ Phone: _____

If not referred, how did you hear about our office? ☐Friend/Family Member ☐Radio ☐Online Search ☐Advertisement

Is this a compensation/accident or work related case? ☐ Yes ☐ No

INSURANCE INFORMATION

Primary Carrier: _____ Policy Holder Name: _____
(if other than patient)

Policy Holder SS#: ____-____-_____ ID #: _____ Group #: _____

Policy Holder DOB: ____/____/____ Policy Holder Employer: _____

Relationship to insured: ☐ Self ☐ Spouse ☐ Child

Secondary Carrier: _____ Policy Holder Name: _____
(if other than patient)

Policy Holder SS#: ____-____-_____ ID #: _____ Group #: _____

Policy Holder DOB: ____/____/____ Policy Holder Employer: _____

Relationship to insured: ☐ Self ☐ Spouse ☐ Child

EMERGENCY CONTACT

Name: _____ Relationship: _____

Phone: _____ _____ _____

Email Address:_____

Would you like to receive updates and correspondence via email? ☐ Yes ☐ No

Your email address will not be used to share Protected Health Information. It may be used to access your secure Patient Portal and/or to receive updates and correspondence from Ark La Tex Foot & Ankle Specialiasts, LLC.

Signature: _____ Date: ____/____/____
(patient or legal guardian)

Patient Name _____ Date of Birth ____/____/____
First Middle Last

PRESENT ILLNESS

What is the reason for your visit? _____

_____

Have you been treated for this condition before today? ☐ Yes ☐ No

If yes, what treatment? _____

How long have you had this condition? _____

Where is the pain located? ☐ Right Foot ☐ Left Foot ☐ Both Feet

Describe your pain: ☐ Aching ☐ Burning ☐ Dull ☐ Sharp ☐ Shooting ☐ Stabbing ☐ Stiff

Severity: ☐ Mild ☐ Moderate ☐ Severe/Extreme

Duration: ☐ Constant ☐ Intermittent

Pain is worse when: ☐ Wearing shoes ☐ Weight bearing ☐ Exercising ☐ Bare foot ☐ At rest
☐ Laying in bed ☐ After running ☐ Wearing heels ☐ Wearing flats

SOCIAL HISTORY

Do you use tobacco? ☐ Yes ☐ No If yes, how many years? _____
☐ Cigarettes ☐ Pipe ☐ Smokeless tobacco ☐ Vapor

		Daily	Occasionally	Socially
Do you drink alcohol? ☐ Yes ☐ No	If so, how often?	☐	☐	☐

What do you drink? ☐ Wine ☐ Beer ☐ Whiskey ☐ Other _____

Are you pregnant? ☐ Yes ☐ No If yes, when is your due date? _____

Fitness Activities? _____ How much per week? _____

FAMILY HISTORY

Mother Date of Birth ____/____/____ ☐ Alive ☐ Deceased - Date ____/____/____

Has your mother ever been diagnosed with any of the following? If so, approximate age at onset? _____

Diabetes Type 1: ☐ Yes ☐ No Heart Disease: ☐ Yes ☐ No

Diabetes Type 2: ☐ Yes ☐ No Hypertension: ☐ Yes ☐ No

Father Date of Birth ____/____/____ ☐ Alive ☐ Deceased - Date ____/____/____

Has your father ever been diagnosed with any of the following? If so, approximate age at onset? _____

Diabetes Type 1: ☐ Yes ☐ No Heart Disease: ☐ Yes ☐ No

Diabetes Type 2: ☐ Yes ☐ No Hypertension: ☐ Yes ☐ No

Patient Name: _____ DOB: ___/___/_____

MEDICAL HISTORY

Height: _____ft _____in **Weight:** _____lbs **Race:** _____ **Shoe Size :** _____

Do you or your immediate family have any of the following?

Self	Family		Self	Family	
☐	☐	Seizure Disorder	☐	☐	DVT
☐	☐	History of a Stroke/TIA	☐	☐	Anesthesia Complications
☐	☐	Alzheimers	☐	☐	Asthma
☐	☐	Dementia	☐	☐	Bronchitis
☐	☐	Anxiety/Nervous Disorder	☐	☐	COPD/Emphysema
☐	☐	Depression	☐	☐	Tuberculosis
☐	☐	Migraines	☐	☐	Sleep Apnea
☐	☐	Hypertension/High Blood Pressure	☐	☐	GERD/Acid Reflux
☐	☐	Heart Disease	☐	☐	Stomach Ulcers
☐	☐	Heart Failure	☐	☐	Hepatitis A B or C
☐	☐	Myocardial Infarction/Heart Attack	☐	☐	Liver Disease
☐	☐	High Cholesterol	☐	☐	Kidney Failure/Disease
☐	☐	Peripheral Vascular Disease	☐	☐	Hemodialysis
☐	☐	Angina/Chest Pain	☐	☐	Thyroid Disease
☐	☐	Heart Murmur	☐	☐	Diabetes ☐ Type I ☐ Type II
☐	☐	Mitral Valve Prolapse			☐ Diet Controlled ☐ Oral Medication ☐ Insulin
☐	☐	Bleeding/Clotting Disorder			☐ Last Hgb A1c_____
☐	☐	Sickle Cell or Sickle Cell Trait	☐	☐	Gout
☐	☐	Cancer Type: _____	☐	☐	Muscle Disease
☐	☐	Pulmonary Embolism	☐	☐	HIV/AIDS
☐	☐	Other _____	☐	☐	Peripheral Neuropathy
			☐	☐	Rheumatoid Arthritis
			☐	☐	Osteoarthritis

PAST SURGICAL HISTORY

Have you had any surgeries/procedures? ☐ Yes ☐ No
If yes, please list: (include all surgeries since childhood)

Year	Surgery	Year	Surgery
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Patient Name: _____ DOB: ___/___/_____

MEDICATION

Do you take medication daily? **(including over the counter, vitamins, or supplements)**

☐ No ☐ Yes If yes, please list:

Name	Strength	Frequency	Reason	Prescribing Physician

Pharmacy of choice: _____ Phone Number: _____

Address/Cross Streets: _____

Are you allergic to any medication and/or food?

☐ No ☐ Yes

Name	Reaction

Signature: _____ **Date:** ___/___/_____

(Patient or Legal Guardian)

Ark La Tex Foot & Ankle Specialists

CONSENT/AUTHORIZATION FORM

Patient Name_____

Consent for Treatment
The information given to this medical facility is correct to the best of my knowledge and I consent to such diagnostic procedures and medical care as deemed necessary by the doctor for my treatment. I also consent to have photographs taken which will be used solely for medical education and/or my medical evaluation.

_____ ____/____/____
Signature: Patient/Legal Guardian **Date**

Insurance Authorization/Payment Policy

Assignment/Release
I, the undersigned, certify that I (or my dependent) have insurance coverage with the above named insurance company(ies), and assign directly to Ark La Tex Foot & Ankle Specialists, LLC, all insurance benefits. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions. I understand that for medical/legal purposes, X-rays and medical records taken/created by this office are the property of Ark La Tex Foot & Ankle Specialists, LLC. I also understand that all charges for services are due and payable at the time the services are rendered, and payment is accepted in the form of cash, check, Mastercard, Visa, Discover and American Express.

_____ ____/____/____
Signature: Patient/Responsible Party **Date**

Medicare Authorization (If Applicable)
I request that payment of Medicare benefits be made on my behalf to Ark La Tex Foot & Ankle Specialists, LLC, for any services furnished to me by that physician. I authorize any holder of medical information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information to pay the claim. If "other health insurance" is indicated in Item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determi nation of the Medicare carrier as the full charge, and I am responsible for only the **deductible, coinsurance,** and **any non- covered** services. Coinsurance and the deductible are based upon the charge determination of the carrier.

_____ _____ ____/____/____
Signature: Patient/Legal Guardian **Date**

Payment Policies
All copays, deductibles, and **coinsurance** are due at the time of service. If you belong to an HMO, you will need a referral. If you belong to a PPO, you may have a deductible. Remember, it is your responsibility as a patient to get a referral if one is required. If you do not have one, you will be responsible for out-of-network benefits. Please let the receptionist know if you have new insurance at your time of arrival. For repeat cancellations without a 24 hour notice, there will be a $25 charge. A $3 billing/finance charge will be added to all accounts after 60 days.

I agree to be responsible for the charges on this account.

_____ ____/____/____
Signature: Patient/Legal Guardian **Date**

Ark La Tex Foot & Ankle Specialists

AUTHORIZATION FOR DISCUSSION OF MEDICAL RECORDS/PRIVACY PRACTICES ACKNOWLEDGMENT

Patient Name _____

I hereby authorize the staff of Ark La Tex Foot & Ankle Specialists, LLC, to disclose information to the following person(s). I am aware this may be my spouse, significant other, child/children, family member, friend, etc. I am aware that if someone were to ask for information concerning my visits with this office that is not listed below, no information could be released to them.

	Name	**Relationship**	**Phone**
1.	_____	_____	_____

☐ Appointments ☐ Test Results ☐ Procedures ☐ Financial ☐ Other _____

2.	_____	_____	_____

☐ Appointments ☐ Test Results ☐ Procedures ☐ Financial ☐ Other _____

3. Do you authorize Ark La Tex Foot & Ankle Specialist to leave a message via voicemail? ☐ Yes ☐ No

This will be effective until I put in writing that I withdraw the above listed person(s).

_____ ____/____/____

Signature: Patient/Legal Guardian **Date**

Notice of Privacy Practices Acknowledgment

I understand that, under the Health Insurance Portability & Accountability Act of 1996, ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

* Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
* Obtain payment from third-party payers.
* Conduct normal health care operations such as quality assessments and physicians certifications.

I have received, read and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

_____ ____/____/____

Signature: Patient/Legal Guardian **Date**