



PATIENT INFORMATION

Patient _____
 Address _____

 Home Phone _____ Work _____ Ext _____
 Sex: M F Age _____ Birthdate _____
 Patient SS# _____
 Occupation _____
 Employer _____
 Employer Address _____
 Employer Phone _____
 Marital Status: Single Married Widowed Separated Divorced
 Spouse's Name _____
 SS# _____ Birthdate _____
 Spouse's Employer _____
 Address _____
 Employer Phone _____
 Whom may we thank for referring you? _____

Are you Diabetic? Yes No
Who is your Treating/Primary Physician? _____
 Address _____
 Phone _____
 Date of Last Visit _____

IN CASE OF EMERGENCY

Who is responsible for your healthcare decisions and can inform us of your medical history, and any additional changes in your patient information, if necessary?

INSURANCE

Who is responsible for this account? _____
 Relationship to Patient _____
 Address _____
 Home Phone _____ Work _____ Ext _____
 Insurance Co. _____
 Group # _____
 Is patient covered by additional insurance? Yes No
 Subscriber Name _____
 Birthdate _____ SS# _____
 Relationship to Patient _____
 Insurance Co. _____
 Group # _____
 Do you need a referral? _____
 Do you have a copay? _____

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage with _____ and assign directly to Kentucky Foot and Ankle Center 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 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.

Relationship _____
 Responsible Party Signature _____

MEDICARE AUTHORIZATION

I Request that payment of authorized benefits be made to Kentucky Foot & Ankle Center for any services furnished me by that physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any 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 necessary to pay the claim. If "other 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, 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 or determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

Beneficiary Signature _____ Date _____

MEDICAL HISTORY UPDATE

If you are a previous patient and have changes since your last visit in your medical history, medications, or allergies, please check here:

CONSENT

I certify that the above information is true and correct to the best of my knowledge. I give my permission to the doctor to administer and perform such procedures as may be deemed necessary in the diagnosis and/or treatment of my feet. In addition by signing my name I am indicating that I have read and understand the privacy policy enacted by Kentucky Foot and Ankle Center.

Patient's Signature _____ Date _____

PODIATRIC HISTORY

What is the chief complaint for which you came to be treated? (Include foot, ankle, knee, thigh, and hip complaints.)

When did it start? _____

What Treatment(s) have been tried? _____

Have you ever been to a Podiatrist before?
 Yes No

If yes, please list.

Name _____

Last Visit _____

Please indicate which foot problems you now have or have had in the past.

- | | | |
|--------------------------------------|------------------------------|-----------------------------|
| Ankle Pain | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Athlete's Foot | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Bunion's | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Corns and Callus | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Cramps and Numbness in Feet and Legs | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Flat Feet | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Foot and Leg Cramps | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Heel Pain | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Ingrown Toenails | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Plantar's | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Swelling in Ankles or Feet | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Tired Feet | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

MEDICAL HISTORY:

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

- | | | | | | |
|----------------------|--|------------------------|--|-----------------------|--|
| Do you smoke: | <input type="checkbox"/> Yes <input type="checkbox"/> No | Do you drink alcohol | <input type="checkbox"/> Yes <input type="checkbox"/> No | AIDS/HIV | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Circulatory Problems | <input type="checkbox"/> Yes <input type="checkbox"/> No | Phlebitis: | <input type="checkbox"/> Yes <input type="checkbox"/> No | Anemia | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Epilepsy | <input type="checkbox"/> Yes <input type="checkbox"/> No | Respiratory Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No | Arthritis | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Fainting | <input type="checkbox"/> Yes <input type="checkbox"/> No | Artificial Heart Valve | | Gout | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Shortness of Breath | <input type="checkbox"/> Yes <input type="checkbox"/> No | or Joints | <input type="checkbox"/> Yes <input type="checkbox"/> No | Asthma | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Headaches | <input type="checkbox"/> Yes <input type="checkbox"/> No | Special Diet | <input type="checkbox"/> Yes <input type="checkbox"/> No | Back Problems | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Stroke | <input type="checkbox"/> Yes <input type="checkbox"/> No | Bleeding Disorders: | <input type="checkbox"/> Yes <input type="checkbox"/> No | Hepatitis of Jaundice | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| High Blood Pressure | <input type="checkbox"/> Yes <input type="checkbox"/> No | Cancer | <input type="checkbox"/> Yes <input type="checkbox"/> No | Kidney Problems | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Ulcers | <input type="checkbox"/> Yes <input type="checkbox"/> No | Liver Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No | Varicose Veins | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Low Blood Pressure | <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | |

Have you ever been diagnosed for any other conditions? _____

Surgeries you have had _____

Hospitalizations other than surgeries listed _____

MEDICATIONS

Include prescriptions, over-the-counter medications and vitamins _____

Pharmacy Name(s) _____

Pharmacy Phone(s) _____

ALLERGIES

No Known Drug Allergies

- | | |
|--|--|
| <input type="checkbox"/> Adhesive/Tape | <input type="checkbox"/> Local Anesthetics |
| <input type="checkbox"/> Anticoagulant Therapy | <input type="checkbox"/> Novocaine |
| <input type="checkbox"/> Aspirin | <input type="checkbox"/> Penicillin |
| <input type="checkbox"/> Codeine | <input type="checkbox"/> Seafoods |
| <input type="checkbox"/> Demerol | <input type="checkbox"/> Sulfa |
| <input type="checkbox"/> Iodine | |
| <input type="checkbox"/> Other _____ | |