Foot & Ankle
SURGICAL ASSOCIATES

Patient Last Name: _____ First Name: _____ MI: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____ Male ☐ Female ☐

Home Phone: _____ Cell Phone: _____

Employer: _____ Employer Phone: _____

Employer Address: _____

Date of Birth: _____ Social Security: _____ Marital Status: _____

Email Address: _____

If Minor: Responsible Party's Name: _____ Date of Birth: _____

Referring Physician: _____ Phone: _____

Emergency Contact: _____ Relation: _____

Emergency Contact's Phone: _____

How did you hear about us? _____

Insurance Policy Information: Please Complete All Information

Primary Plan: _____ Group Number: _____

Insurance ID Number: _____ Subscriber's Name: _____

Date of Birth: _____ Employer: _____

Secondary Plan: _____ Group Number: _____

Insurance ID Number: _____ Subscriber's Name: _____

Date of Birth: _____ Employer: _____

If this is a work related injury: Industrial Insurance Carrier: _____

Phone: _____ Date of Injury: _____ Claim Number: _____

Medical and Podiatric Information

Family Physician: _____ City: _____ Last Visit: _____

Pharmacy of Choice: _____ Phone: _____

Former Podiatrist Name: _____ Last Visit: _____

Foot & Ankle
SURGICAL ASSOCIATES

Consent to Treatment, Insurance Authorization and Assignment

I authorize medical care for _____. I hereby authorize my insurance benefits to be paid directly to the physician. I am financially responsible for all services according to the Foot & Ankle Surgical Associates (FASA) policy, regardless of pending insurance claims.

I understand that my express consent is required for the medical provider to release any information regarding diagnosis and/or treatment of HIV (AIDS Virus), sexually transmitted disease, drug or alcohol abuse, psychiatric treatment or mental illness. If I have been treated or diagnosed in connection to HIV (AIDS Virus), sexually transmitted disease, drug or alcohol abuse, psychiatric treatment or mental illness, you are specifically authorized to release to the insurance company in my medical file all information or medical records relating to the diagnosis or treatment.

Assignment of Benefits

I attest that the information I have provided to FASA is correct and true to the best of my knowledge. I hereby assign any medical and/or surgical benefits to FASA. This assignment will remain in effect until revoked by me in writing. A photocopy of the assignment is to be considered as valid as the original. I understand that I am financially responsible for all charges, whether or not paid by said insurance. I further authorize FASA to release all information to secure payment.

Assignment to Release Information

I hereby authorize any physician, hospital, pharmacy or medical facility to provide all information regarding my medical or pharmaceutical history and treatment to FASA. I further will allow my pharmacy to supply verification of benefits. I also authorize FASA to release my medical information to other physicians as needed to facilitate treatment.

Text/Email Consent Form

I have read and acknowledged the text/email consent policy.

Patient Signature: _____ Date: _____

If a minor: Parent or Legal Guardian: _____ Date: _____
*If the patient has reached his/her 14th birthday, ONLY the patient may authorize disclosure relating to sexually transmitted disease.

Medicare Authorization and Assignment

I authorize any holder of medical or other information about me to release to the Social Security Administration and Healthcare Financing Administration or its intermediaries or carriers any information necessary for this or related Medicare claim/other insurance claim. I permit copy of this authorization to be used in the place of the original, and request payment of medical insurance benefits to the party who accepts the assignment. Regulation pertaining to Medicare assignment of benefits applies. I understand it is mandatory to notify the health care provider of any party who may be responsible for my treatment. (Section 128B of the Social Security Act and 31 U.S.C. 3801-3812 provides penalties for withholding this information.)

Patient Signature: _____ Date: _____

Foot & Ankle
SURGICAL ASSOCIATES

Acknowledgment or Receipt of Notice of Privacy Practices

I acknowledge that I was provided with a copy of the Notice of Privacy Practices.

_____ _____

Patient Name (please print) Date

_____ Signature

1. Cancellation/No Show policy for Doctor Appointments

At Foot & Ankle Surgical Associates your scheduled appointment is very important. We have a policy for patients who do not show up for their appointments, or who fail to give **24 hours' notice** of canceling or rescheduling their scheduled appointment. **There is a $50.00 charge for failure to follow this policy.**

2. Scheduled Appointments

We understand that delays can happen. However, we must try to keep the other patients and doctors on time. **If a patient is 15 minutes past their scheduled time, we will have to reschedule the appointment.**

3. Cancellation/No Show Policy for Surgery

Due to the large block of time needed for surgery, late cancellations cause problems and added expenses to the office. **If the surgery is not cancelled at least 10 days in advance, you will be charged a $200 fee. This will not be covered by your insurance company.**

I have read and acknowledge the above policy.

_____ _____

Patient Name (please print) Date

_____ Signature

Foot & Ankle
SURGICAL ASSOCIATES

Medical History Form

Patient Name: _____ Referring Doctor: _____

Your answers on this form will help your clinician understand your medical concerns and conditions better. If you are uncomfortable with any of the questions, do not answer them. Best estimates are fine if you cannot remember specific details.

Symptom Area (left/right leg/foot/toes/ankle): _____
When did you first notice symptoms (date): _____

Describe how your symptoms began: _____

Treatment (if any) to date: _____ Has it helped? _____

Medications: Prescription and non-prescription medicines, vitamins/supplements, home remedies, birth control pills, herbs

	MEDICATION	DOSE		MEDICATION	DOSE
1			6		
2			7		
3			8		
4			9		

Allergies or Reactions to Medications:

MEDICATION	REACTION/SIDE EFFECT

Surgical History:

	OPERATION	DATE		OPERATION	DATE
1			5		
2			6		
3			7		
4			8		

Social History:

Occupation: _____

Height: _____ft. _____in. Shoe Size: _____ Weight: _____ lbs.

Women: Possibility of pregnancy? Yes / No

Tobacco use? Yes / No Number of packs/cans per day: _____

Alcohol use? Yes / No How much/often: _____

Street drug use? Yes / No Drug names: _____ Last use: _____

Personal Medical History: Please indicate with a ✓ whether you have had any of the following medical problems.

Foot & Ankle
SURGICAL ASSOCIATES

MEDICAL CONDITION		MEDICAL CONDITION		MEDICAL CONDITION	
Heart Problems		Ulcers		Thyroid/Glandular Problems	
Heart Attack		Stroke		Cancer-Where:	
Angina/Chest Pain		Diabetes Type I / II		Arthritis-Where:	
Kidney Problems		Stomach Problems		Paralysis/Weakness	
Breathing Problems		High Blood Pressure		Problems With Surgery	
Lung Disease		Psychiatric/Emotional Problems		Osteoporosis	
Bleeding Problems		Other:		Other:	

Family History: Please indicate with a ✓ family members who have had any of the following medical problems.

MEDICAL CONDITION	MOM	DAD	SISTER	BROTHER	DAUGHTER	SON	OTHER
Alcoholism							
Anemia							
Anesthesia Problems							
Arthritis							
Asthma							
Bleeding Problems							
Cancer-Type:							
Depression							
Diabetes Type I							
Diabetes Type II (Adult Onset)							
Eczema							
Heart Attack (Coronary Artery Disease)							
High Blood Pressure							
High Cholesterol							
Kidney Disease							
Lupus							
Migraines/Headaches							
Mitral Valve Prolapse							
Osteoarthritis							
Osteoporosis							
Rheumatoid Arthritis							
Stroke							
Thyroid Disorders							
Tuberculosis							
Epilepsy (Seizures)							

Foot & Ankle
SURGICAL ASSOCIATES

Do I Need a Test for PAD?

Peripheral Arterial Disease (PAD) is a serious circulatory problem in which the blood vessels that carry blood to your arms, legs, brain, or kidneys, become narrowed or clogged. It affects over 8 million Americans, most over the age of 50. It may result in leg discomfort with walking, poor healing of leg sores/ulcers, difficult to control blood pressure, or symptoms of stroke. People with PAD are at significantly increased risk for stroke and heart attack. Answers to these questions will determine if you are at risk for PAD and if a vascular exam will help us better assess your vascular health status.

Name: _____ Date: _____

Circle "Yes" or "No"			Test for PAD
Do you have foot, calf, buttock, hip or thigh discomfort (aching, fatigue, tingling, cramping or pain) when you walk which is relieved by rest?	Yes	No	☐
Do you experience any pain at rest in your lower leg(s) or feet?	Yes	No	☐
Do you experience toe or foot pain that often disturbs your sleep?	Yes	No	☐
Are your toes or feet pale, discolored, or bluish?	Yes	No	☐
Do you have skin wounds or ulcers on your feet or toes that are slow to heal (8-12 weeks)?	Yes	No	☐
Has your doctor ever told you that you have diminished or absent pedal (foot) pulses?	Yes	No	☐
Have you suffered a severe injury to the leg(s) or feet?	Yes	No	☐
Do you have an infection of the leg(s) or feet that may be gangrenous (black skin tissue)?	Yes	No	☐

Patient Signature: _____

Physician Signature: _____ Date: _____