FAIRBANKS FOOT & ANKLE, INC.

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PATIENT INFORMATION

Patient Name: _____ Date of Birth: _____ Age: ____ Sex: M F
(First Name - Middle Initial - Last Name)

Preferred Name: _____

Guarantor Name (if patient is under 18): _____ Relationship: _____

Social Security Number: _____ Marital Status: S / M / D / W

Mailing Address: _____ City/State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ E-mail: _____

Employer: _____ Occupation: _____

Emergency Contact: _____ Relationship: _____ Phone: _____

Primary Care Doctor: _____ Pharmacy: _____

Who is responsible for payment: _____ Relationship: _____

Who Referred You To Us: _____

INSURANCE

Primary Insurance Company Name: _____

Policy Holder Name: _____ Date of Birth _____

ID # _____ Group # _____

Secondary Insurance Company Name: _____

Policy Holder Name: _____ Date of Birth _____

ID # _____ Group # _____

FINANCIAL POLICY

- As our patient, you are responsible for all authorizations/referrals needed to seek treatment in this office.

- Unless other arrangements have been made in advance by you, or your health insurance carrier, payment for office services are due at the time of service. We will accept VISA, MasterCard, Discover Card, American Express, cash or check.

- Your insurance policy is a contract between you and your insurance company. As a courtesy, we will file your insurance claim for you if you assign the benefits to the doctor. In other words, you agree to have your insurance company pay the doctor directly. If your insurance company does not pay the practice within a reasonable period, we will have to look to you for payment.

- We have made prior arrangements with certain insurers and other health plans to accept an assignment of benefits. We will bill those plans with which we have an agreement and will only require you to pay the co-pay/co-insurance/deductible at the time of service.

- If you have insurance coverage with a plan with which we do not have a prior agreement, we will prepare and send the claim for you on an unassigned basis. This means your insurer will send the payment directly to you. Therefore, all charges for your care and treatment are due at the time of service.

- All health plans are not the same and do not cover the same services. In the event your health plan determines a service to be "not covered," or you do not have an authorization, you will be responsible for the complete charge. We will attempt to verify benefits for some specialized services or referrals; however, you remain responsible for charges to any service rendered. Patients are encouraged to contact their plans for clarification of benefits prior to services rendered.

- You must inform the office of all-insurance changes and authorization/referral requirements. In the event the office is not informed, you will be responsible for any charges denied.

- For most services provided in the hospital, we will bill your health plan. Any balance due is your responsibility.

- There are certain elective surgical procedures for which we require pre-payment. You will be informed in advance if your procedure is one of those. In that event, payment will be due one week prior to the surgery.

- Past due accounts are subject to collection proceedings. All costs incurred including, but not limited to, collection fees, attorney fees and court fees shall be your responsibility in addition to the balance due this office.

- There is a service fee of $35.00 for all returned checks. Your insurance company does not cover this fee.

To the best of my knowledge, I have answered the demographic, financial and health questions accurately. I understand that providing incorrect information can be dangerous to my health. I understand that it is my responsibility to inform the doctor and office staff of any changes in my medical status or insurance coverage. I have had the opportunity to review the HIPAA Notice of Privacy Practices.

_____ _____

Signature of Patient/Responsible Party: Date

_____ _____

Signature if other than patient, relationship to patient Date

CURRENT PROBLEM -

Reason for today's visit? _____

How long ago did this start? ___# Days ___# Weeks __# Months __# Years

Please describe your problem:

_____

_____

_____

How would you rate your pain on a scale from 0 (no pain) to 10 (worst)? _____

What treatments have you tried for this problem:

None Rest Ice Compression Elevation Splint Medication Other:_____

Height: _____ **Weight**: _____ **Shoe Size**: _____

Where is the pain/problem located? Please mark on the pictures below.

LEFT FOOT

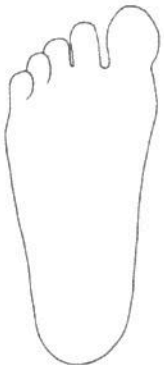
TOP OF FOOT

BOTTOM OF FOOT

INSIDE OF FOOT

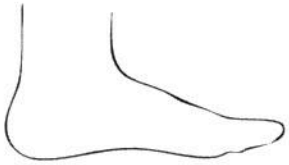
OUTSIDE OF FOOT

RIGHT FOOT

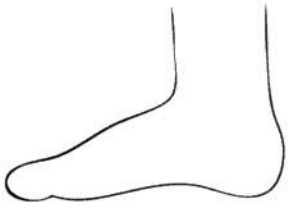


BOTTOM OF FOOT

TOP OF FOOT



OUTSIDE OF FOOT



INSIDE OF FOOT

ALLERGIES **No Known Allergies**

_____

MEDICATIONS - List all medications you are currently taking or circle **NONE**
(Prescriptions, over-the-counter medications and herbal supplements)

Name Reason Dose

_____

_____

_____

MEDICAL HISTORY - **NONE**

Abnormal Bleeding____	Acute Infection_____	Arthritis_____	Asthma_____	Back Problem____
Bleeding tendency____	Blood Clots_____	Blood Transfusion____	Diabetes_____	HIV/AIDS_____
Kidney Disease_____	Liver Disease_____	Neuropathy_____	Open Sores____	Pneumonia_____
High Blood Pressure___	Psychiatric Care_____	Shortness of Breath____	Skin Disorder___	Sleep Apnea_____
Stomach Ulcers_____	Stroke_____	Tuberculosis_____	Pregnant/Nursing_____	**OTHER**: _____

SURGERY/HOSPITALIZATIONS - **NONE**

Type of Surgery Date Type of Surgery Date

_____

_____

FAMILY HISTORY – **NONE**

	Family Member:		**Family Member:**
Arthritis	_____	High Blood Pressure	_____
Asthma	_____	Stroke	_____
Cancer	_____	Thyroid Disease	_____
Diabetes	_____	Coronary Heart Disease	_____
Emphysema	_____	Heart Disease	_____
Foot Problem	_____		

SOCIAL HISTORY:

	Current	Past	Never	Other
Use of Alcohol:	_____	_____	_____	_____
Use of Tobacco:	Heavy/Light	_____	_____	_____
Substance Abuse:	_____	_____	_____	_____
Recreational Drugs:	_____	_____	_____	_____

PATIENT NAME: _____

In the **last 3 months** have you experienced:

CONSTITUTIONAL			IMMUNOLOGIC		
Fever	Yes	No	Chemotherapy	Yes	No
Chills	Yes	No	High Dose Steroid	Yes	No
Sweats	Yes	No	Immunocompromised	Yes	No
Weakness	Yes	No	Recurrent infections	Yes	No
Fatigue	Yes	No	MUSCULOSKELETAL		
EYE			Back pain	Yes	No
Recent visual problem	Yes	No	Neck pain	Yes	No
EARS			Joint pain	Yes	No
Decreased hearing	Yes	No	Muscle pain	Yes	No
Ear pain	Yes	No	Decreased joint motion	Yes	No
RESPIRATORY			INTEGUMENTARY		
Shortness of breath	Yes	No	Rash	Yes	No
Cough	Yes	No	Dryness	Yes	No
Sputum production	Yes	No	Skin lesion	Yes	No
Spitting blood	Yes	No	Hypertrophic Scar	Yes	No
Wheezing	Yes	No	Keloid	Yes	No
CARDIOVASCULAR			NEUROLOGIC		
Chest pain	Yes	No	Abnormal balance	Yes	No
Palpations	Yes	No	Confusion	Yes	No
Swelling of feet	Yes	No	Numbness	Yes	No
GASTROINTESTINAL			Tingling	Yes	No
Nausea	Yes	No	Headache	Yes	No
Vomiting	Yes	No	PSYCHIATRIC		
Diarrhea	Yes	No	Anxiety	Yes	No
Constipation	Yes	No	Depression	Yes	No
Heartburn	Yes	No	Mania	Yes	No
Abdominal pain	Yes	No	Suicidal	Yes	No
GENITOURINARY			Delusional	Yes	No
Painful urination	Yes	No	Hallucinations	Yes	No
Blood in urine	Yes	No			
HEAM/LYMPH					
Bruising tendency	Yes	No			
Bleeding tendency	Yes	No			
ENDOCRINE					
Excessive thirst	Yes	No			
Frequent urination	Yes	No			
Cold intolerance	Yes	No			
Heat Intolerance	Yes	No			