ANIMAS
FOOT & ANKLE

Name: _____ **DOB**: _____
Address:_____ **City**:_____ **State**:_____ **Zip**:_____
E-mail:_____ **SS#**: _____
Home#: _____ **Cell#**: _____ **Other#**: _____
Sex: ☐ **M** ☐ **F** **Race**: _____ **Ethnicity**: _____
Marital Status: ☐ **Single** ☐ **Married** ☐ **Widowed** ☐ **Divorced** **Spouse/Partner Name**: _____
Employer: _____ **Phone**: _____
Employer Address: _____ **City**: _____ **State**:_____ **Zip**:_____
Emergency Contact Name:_____ **Relationship**:_____ **Phone**:_____

Primary Insurance:_____ **Are you the Patient?**: ☐**Yes** ☐**No**
Insured Information
Subscriber Name: _____ Relationship to Patient: ☐Spouse ☐Child ☐Self ☐other
Phone #:_____ Sex: ☐Male ☐Female DOB: __/__/_____
Address:_____ SS#: _____
Policy ID:_____ Group ID:_____ Employer:_____
Secondary Insurance:
Subscriber Name: _____ Relationship to Patient: ☐Spouse ☐Child ☐Self ☐other
Phone #:_____ Sex: ☐Male ☐Female DOB: __/__/_____
Address:_____ SS#: _____
Policy ID:_____ Group ID:_____ Employer:_____

Primary Care Provider:_____ **Date last seen**:_____
Referring Physician:_____ **Date last seen**:_____
Preferred Pharmacy:_____ **Location**: _____

Current Medications:
☐No known Medications ☐ I take the following medications
Name / Dose: _____
Name / Dose: _____
Name / Dose: _____
Name / Dose: _____
Name / Dose: _____
Name / Dose: _____

Allergies:
No known Allergies ☐ No Known Drug Allergies
Name / Reaction: _____
Name / Reaction: _____
Name / Reaction: _____
Name / Reaction: _____
Name / Reaction: _____
Name / Reaction: _____

Age:____ **Shoe Size**:_____
Height:_____ **Weight**:_____
Last Blood Pressure: _____/_____

Smoking Status:
☐Everyday ☐Some Day ☐Former ☐Never
☐Trying to Quit ☐Ready to Quit

Please Read and Sign: The above information is correct to the best of my knowledge. I understand that throughout my treatment, I am responsible for notifying the physician and/or medical staff of any and all updates to the information listed above.

Patient Signature:_____ **Date**: _____

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Name:_____ **DOB:**_____

How did you find out about our practice: ☐Physician ☐Internet ☐Phone book ☐Family member ☐Friend

Other:_____

What is the reason for your visit today:_____

Which side is bothering you?: ☐Right ☐Left ☐Both **Result of an accident or work injury?:** ☐Yes ☐No

How long has this bothered you? 1 2 3 4 5 6 7 ☐days ☐weeks ☐months ☐years

On a scale of 1-10, how bad is your pain?

Describe your pain (circle all that apply):

Sharp Dull Aching Throbbing Cramping Itching Popping Burning

Tingling Clicking Shooting Stabbing Other:_____

Which treatments have you tried & were they effective?_____

_____

Medical History:

- ☐ Liver Disease
- ☐ Blood Clot
- ☐ Neuropathy
- ☐ Heart Disease
- ☐ Gout
- ☐ Heartburn
- ☐ Back pain
- ☐ Circulation problems
- ☐ Anxiety disorder
- ☐ High blood pressure
- ☐ Varicose Veins
- ☐ Diabetes Type I/II
- ☐ Blood disorders
- ☐ High Cholesterol
- ☐ Other: _____
- ☐ Asthma
- ☐ Osteomyelitis
- ☐ CVA
- ☐ Stroke
- ☐ Arthritis
- ☐ Cancer
- ☐ Allergies
- ☐ Other:_____
- ☐ Breathing issues
- ☐ Epilepsy/Seizures
- ☐ Dementia/Alzheimer's
- ☐ Raynaud's disease
- ☐ Musculoskeletal
- ☐ Kidney disease
- ☐ Skin disorders

Are you pregnant? ☐Yes ☐No **Are you nursing?** ☐Yes ☐No

Surgical History: ☐ None ☐Appendectomy ☐Angioplasty ☐Cholecystectomy ☐Hip Replacement ☐Knee Replacement ☐Shoulder Replacement ☐Other:_____

Have you ever had any surgical procedure on your foot or ankle? ☐Yes ☐No When?:_____

If yes, please describe:_____

Do you have any artificial joints? ☐Yes (where?_____) ☐No Pacemaker or stent? ☐Yes ☐No

Social History:

Do you drink alcohol? ☐Yes, everyday (5-7 days/week) ☐Yes, occasionally/socially ☐No/Rarely

Do you exercise regularly? ☐No ☐Yes, I do the following regular exercise:_____

Please Read and Sign: The above information is correct to the best of my knowledge. I understand that throughout my treatment, I am responsible for notifying the physician and/or medical staff of any and all updates to the information listed above.

Patient Signature:_____ **Date**: _____

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Name:_____ **DOB:**_____

Family History: Is there any family history (blood relative) of: *(Please indicate family member)*

☐ Alzheimer's	_____	☐ Depression	_____
☐ Arthritis	_____	☐ Diabetes	_____
☐ Bleeding disorders	_____	☐ Gout	_____
☐ Blood Clot	_____	☐ Heart Disease	_____
☐ Cancer	_____	☐ High Blood Pressure	_____
☐ Circulation Problems	_____	☐ Neurological	_____
☐ Other (specify)	_____	☐ Strokes	_____

Review of Systems: *(Please check box if you currently have any of these symptoms or check "NONE")*

Cardiovascular	☐leg pain when walking ☐fever ☐chest pain/pressure ☐leg swelling ☐cold hands/feet ☐fainting ☐palpitations ☐vascular disease ☐valve problems ☐**NONE**
Gastrointestinal	☐abdominal pain ☐heartburn ☐vomiting ☐ulcers ☐blood in stool ☐constipation ☐diarrhea ☐trouble swallowing ☐decreased appetite ☐increased appetite ☐**NONE**
Integumentary	☐athletes foot ☐nail abnormalities ☐keloids ☐itchiness ☐dry skin ☐gout ☐**NONE**
Hematologic	☐lower leg ulcers ☐sickle cell disease ☐anemia ☐blood thinners ☐clotting disorder ☐**NONE**
Neurological	☐tingling ☐weakness ☐seizures ☐numbness ☐headaches ☐tremors ☐paralysis ☐**NONE**
Musculoskeletal	☐back pain ☐joint swelling ☐muscle weakness ☐muscle pain ☐neck pain ☐sciatica ☐joint stiffness ☐joint pain ☐joint instability ☐arthritis ☐**NONE**
Respiratory	☐chest pain ☐wheezing ☐COPD ☐coughing ☐snoring ☐shortness of breath ☐emphysema ☐**NONE**
Orthopedic	☐foot pain ☐ankle pain ☐toe joint pain ☐knee pain ☐hip pain ☐back pain

Last Flu Shot Date: _____ **Did you get a pneumococcal vaccination?** ☐Yes ☐No

Have you fallen in the last 12 months? ☐Yes ☐No **Were you injured from the fall?** ☐Yes ☐No

Advanced Directives: ☐Living Will ☐DNR ☐Durable Power of Attorney ☐Surrogate Appointed ☐NONE

Privacy Information Preferences: Can we call the number on file? ☐Yes ☐No **Can we leave a message?** ☐Yes ☐No

Will you allow us to send internet based (email) or text delivery of reminders? Yes No

If yes, please provide your email address: _____

Who can we leave message with? ☐Wife ☐Husband ☐Daughter ☐Son ☐Other: _____

Name(s): _____

PLEASE READ AND SIGN: The information on my intake form(s) is correct to the best of my knowledge. I understand that throughout my treatment, I am responsible for notifying the physician and/or medical staff of any changes and all updates to the information listed above. *(Assignment of Benefits):* I authorize payment of medical benefits to the practice indicated above. *(Release of Information*): I authorize the release of any medical information necessary to process the claim. *(HIPAA Privacy):* I acknowledge that I received my HIPAA Privacy Notices. *(Medication History):* I authorize the Doctor's office to retrieve my medication history. I hereby consent to medical treatment, diagnostic tests, laboratory or other procedures, which the physician(s) or other health care provider(s) of Animas Foot and Ankle may consider or advise in my treatment, or in treatment of my dependent. This agreement will remain in effect until I choose to revoke it in writing.

Patient Signature:_____ **Date:** _____

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Financial Policy

I agree to be financially responsible for costs incurred for my, or my dependent's care. I understand that, as a courtesy, Animas Foot and Ankle will bill my insurance and that this does not transfer my financial obligation for services rendered to Animas foot and Ankle.

Please read carefully, initial and sign where indicated to acknowledge your understanding and acceptance. If you are a minor (under 18), your parent or legal guardian must accept financial responsibility on your behalf.

____ I understand and accept that I am ultimately financially responsible for all expenses incurred for services provided, regardless of my insurance status.

____ Payment is expected and due at the time of service for co-payments, co-insurance and/or deductibles that may be required by my insurance company.

____ I understand that I am responsible for the verification of my insurance coverage and benefit level for services rendered by Animas Foot and Ankle providers and providers to whom I am referred to by Animas Foot and Ankle.

____ I understand that if, 90 days after billing, my insurance company has not paid, my account will be due and payable by me.

____ In the event that my account becomes past due, my balance may be turned over to a collection agency for collection of balances on my account. I understand that if I have a balance in collections, I may pay the balance in full prior to being seen by Animas Foot and Ankle for subsequent visits.

____ I understand that I may be subject to a $50.00 fee, if I cancel within 24 hours of my appointment time.

____ I understand that I will be charged a $20.00 non-sufficient funds fee for any returned check. Any payments thereafter must be made with cash or a credit card.

____I understand that Animas Foot and Ankle will NOT bill my insurance company for any over the counter medical equipment that I may purchase. This includes but is not limited to scooter rentals, ice machines, ankle braces, orthotics, ice packs, compression sleeves, toe spacers, arch supports, toe sleeves and gel pads.

____ I understand that certain services may be sent to an outside source such as a lab, pathology, diagnostic imaging services or specialty prescription medications and thus will be billed separately for those services.

Patient/responsible party/guardian signature: _____ **Date**: _____

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Consent of Disclosure

I hereby state that by signing this consent I acknowledge and agree to the following:

1. Animas Foot and Ankle's Privacy Notice has been provided to me prior to my signing this consent. The Privacy Notice includes a complete description of the uses and/or disclosures of my protected health information (PHI) necessary for Animas Foot and Ankle to obtain payment for that treatment and to carry out its health care operations. Animas Foot and Ankle explained to me that the Privacy Notice will be available to me in the future at my request. Animas Foot and Ankle has further explained my right to obtain a copy of the Privacy Notice prior to signing this consent, and has encouraged me to read the Privacy Notice carefully prior to my signing this consent.

2. Animas Foot and Ankle reserves the right to change its privacy practices that are described in its Privacy Notice, in accordance with applicable law.

3. I understand that, and consent to, the following appointment reminders will be used by Animas Foot and Ankle.
    a. Telephoning my home or cell and leaving a message on my voicemail/answering machine.
    b. Sending a text message to my cell phone that I listed above.
    c. Sending an email to my email address listed above.

4. Animas Foot and Ankle may use and/or disclose my PHI (which includes information about my health or condition and treatment provided to me) in order for Animas Foot and Ankle to treat me and obtain payment for that treatment, and as necessary for Animas Foot an Ankle to conduct its specific health care operations.

5. I understand that I have a right to request that Animas Foot and Ankle restrict how my PHI is used and/or disclosed to carry out treatment, payment and/or health care operations. However, Animas Foot and Ankle is not required to agree to any restrictions that I have requested. If Animas Foot and Ankle agrees to a request restriction, then the restriction is binding.

6. I understand that this consent is valid for seven years. I further understand that I have the right to revoke this consent in writing, at any time, for all future transactions, with the understanding that any such revocation shall not apply to the extent that Animas Foot and Ankle has already taken action in reliance on this consent.

7. I understand that if I revoke this consent at any time, Animas Foot and Ankle has the right to refuse to treat me.

8. I understand that if I do not sign this consent evidencing my consent to the uses and disclosures described to me above and contained in the Privacy Notice, then Animas Foot and Ankle will not treat me.

I have read and understand the foregoing notice, and all of my questions have been answered to my full satisfaction in a way that I can understand.

Patient or responsible party signature: _____ **Date:** _____

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X-Ray Questionnaire

Name: _____ DOB: _____

	Yes	No
1. Have you had a recent fracture?	☐	☐
a. If yes, where/when?_____		
2. Have you had a vertebral compression fracture?	☐	☐
a. If yes, which level(s)? _____		
3. Are you a current smoker or tobacco user?	☐	☐
4. Do you take prednisone or other glucocorticoids?	☐	☐
5. Have you ever had a bone density or DEXA Scan?	☐	☐
a. If yes, When? _____ Facility _____		
6. Are you on or have you been on medication for osteoporosis?	☐	☐
a. If yes, which one? _____		
b. How long? _____		
7. Have you been diagnosed with reflux or GERD?	☐	☐
8. Do you have any of the following conditions? (circle all that apply)	☐	☐
a. Paget's Disease, Bone Metastases, Hypercalcemia Disorder		
9. Do you have a history of cancer or radiation treatment?	☐	☐
a. If yes, please provide details_____		

For Women Only

10. Are you Post-menopausal?	☐	☐
11. Have you had a hysterectomy or tubal ligation?	☐	☐
12. Is there any possibility you could be pregnant?	☐	☐
13. What was the date of your last menstrual period? _____	☐	☐

Patient Signature (required) _____ **Date:** _____