

## WELCOME TO ANP FOOT & ANKLE CLINIC

Patients First Name: \_\_\_\_\_ MI: \_\_\_\_\_ Last: \_\_\_\_\_ Sex: Male Female

Date Of Birth: \_\_\_\_\_ Soc. Sec. #: \_\_\_\_\_ Today's Date: \_\_\_\_\_

Nickname: \_\_\_\_\_ Marital Status: S M D W Spouse's Name: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Email: \_\_\_\_\_ Preferred Phone #: \_\_\_\_\_ Alternative Phone #: \_\_\_\_\_

May we leave a message on the phone? Yes No Comments: \_\_\_\_\_

In case of emergency, notify: \_\_\_\_\_ Phone: \_\_\_\_\_ Relationship: \_\_\_\_\_

### FINANCIAL RESPONSIBILITY

Cash

Person responsible for account:	Street Address (if different):	
Relationship to patient:	City, State:	Sex: Male Female
Preferred Phone #:	Soc. Sec. #:	ZIP:
Date of birth:	Work Phone #:	Employer:

### PRIMARY INSURANCE

Company:	Date of birth for subscriber:
Subscriber:	Soc. Sec. #:

### SECONDARY INSURANCE

Company:	Date of birth for subscriber:
Subscriber:	Soc. Sec. #:

### SERVICES AND PERMISSION

I ACKNOWLEDGE THAT I WAS PROVIDED A COPY OF THE NOTICE OF PRIVACY PRACTICES AND THAT I HAVE READ (OR HAD THE OPPORTUNITY TO READ IF I SO CHOSE) AND UNDERSTOOD THE NOTICE.

I HEREBY AUTHORIZE SUCH MEDICAL, TREATMENT, AND DIAGNOSTIC TESTS AS MAY BE RECOMMENDED BY THE ANP FOOT & ANKLE CLINICS, DOCTORS AND STAFF TO EXAMINE, DIAGNOSE AND TREAT MY PODIATRIC AILMENTS. I UNDERSTAND THERE IS NO WARRANTY OF RESULT OR CURE. THIS CONSENT WILL REMAIN IN EFFECT UNTIL I WITHDRAW W MY REQUEST IN WRITING.

I HEREBY REQUEST THAT THE PAYMENT OF AUTHORIZED INSURANCE/MEDICARE BENEFITS BE MADE DIRECTLY TO THE ANP FOOT & ANKLE CLINICS ON MY BEHALF FOR ANY SERVICES PROVIDED TO ME BY ANP FOOT & ANKLE CUNICS. I AUTHORIZE ANP FOOT & ANKLE CLINIC'S DOCTORS AND STAFF TO RELEASE ANY MEDICAL OR OTHER INFORMATION ABOUT ME, NEEDED TO DETERMINE THE BENEFITS FOR THE SERVICES, TO THE HEALTH CARE FINANCING ADMINISTRATION AND OR MY HEALTH INSURANCE COMPANY AND ITS AGENTS.

I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT PAID BY INSURANCE; AND I AM SUBJECT TO ANY LATE OR SERVICE FEES FOR ANY UNPAID BALANCE. I AUTHORIZE THE USE OF MY SIGNATURE ON ALL INSURANCE SUBMISSIONS.

Please print patient's name: \_\_\_\_\_

Signature of patient, parent, guardian: \_\_\_\_\_ Date: \_\_\_\_\_

ALLERGIES	
Yes	No
If yes:	
1. _____	
2. _____	
3. _____	
4. _____	
5. _____	

MEDICATIONS (WITH DOSAGES)	
Yes	No
If yes:	
1. _____	
2. _____	
3. _____	
4. _____	
5. _____	

PHARMACY LOCATION
Address 1
Street: _____
State: _____ Zip: _____
Address 2 (if applicable)
Street: _____
State: _____ Zip: _____

TODAY'S VISIT	
What brings you by the office today? _____	
Left Foot	Right Foot
Both	How long has it been going on? _____
How severe is the pain?	1 2 3 4 5 6 7 8 9 10
Comments: _____	
Name of family/regular doctor: _____	

GENERAL HEALTH			
AIDS	High Blood Pressure	Knee Pain	Cancer _____
Alcoholism	Depression/Anxiety	Ankle Pain	COPD
Alzheimers	Heart Attack	Diabetes	Hepatitis (A) (B) (C)
Anemia	Neck Pain	Drug Abuse	Aching Feet
Arthritis (Rheumatoid)	Back Pain	Plantar Fasciitis	Other Health Problems:
Asthma	Hip Pain	Seizures	<div style="border: 1px solid black; height: 40px; width: 100%;"></div>
Smoker (Current or Former)	Ulcers	Kidney	
	Gout	Stroke	

SURGICAL HISTORY			
Carpal Tunnel	Knee	Back	Other Surgeries:
Gallbladder	Hip	Thyroid	<div style="border: 1px solid black; height: 60px; width: 100%;"></div>
Appendix	Pacemaker	Hernia	
Shoulder	Stent	Vascular	
Ankle	Cardiac (Heart)	Foot Surgery	