Welcome to ANP FOOT AND ANKLE CLINIC

HOW DID YOU HEAR ABOUT OUR OFFICE ______________________ *REFERRED BY:* ________________

PATIENTS NAME (FIRST) ______________________ (MI) ___ (LAST) ______________________
DATE OF BIRTH ___/___/______ SOC. SEC # ______/____/__________ TODAY'S DATE ___/___/_____
SEX: (M) (F) NICKNAME __________ MARITAL STATUS (S) (M) (D) (W) SPOUSE'S NAME ________________
ADDRESS ____ CITY ____________________
STATE __________ ZIP CODE ______________ YOUR E-MAIL ________________________
PREFERRED PHONE# ______________________________ ALT PHONE # ____________________
MAY WE LEAVE MESSAGE ON THE PHONE? (Y)(N) COMMENTS: ________________________
IN CASE OF EMERGENCY NOTIFY ____
PHONE # ______________________ RELATIONSHIP ____________________________

FINANCIAL RESPONSIBILITY

PERSON RESPONSIBLE FOR ACCOUNT		DATE OF BIRTH
RELATIONSHIP TO PATIENT	SSN#	MALE ☐ FEMALE ☐
ADDRESS (IF DIFFERENT)	CITY, ST	ZIP
PREFERRED PHONE	WORK PHONE	EMPLOYER

PRIMARY INSURANCE

CASH ☐

COMPANY	DATE OF BIRTH FOR SUBSCRIBER
SUBSCRIBER	SSN#

SECONDARY INSURANCE

COMPANY	DATE OF BIRTH FOR SUBSCRIBER
SUBSCRIBER	SSN#

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 RECOMMENED 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 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 CLINICS. 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 ____________

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D L____ INS CARD____ INS VER ____ MA____ N S____ DRG ____ B D____

ALLERGIES

None____

____
____
____
____

MEDICATIONS (with dosages)

We can copy a list if you have one with you

None____

____
____
____
____
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TODAY'S VISIT

What brings you to the office today? ______________________________

RT Foot ____ LT Foot ____ Both ____ How Severe is the pain? 0-1-2-3-4-5-6-7-8-9-10

How long has it been going on? ______________________________

Comments: ______________________________

FAMILY/REGULAR DOCTOR: ______________________________

GENERAL HEALTH

- AIDS
- Alcoholism
- Alzheimers
- Anemia
- Arthritis (Rheumatoid)
- Asthma
- High Blood Pressure
- Heart Attack
- Stroke
- Neck Pain
- Back Pain
- Hip Pain
- Knee Pain
- Ankle Pain
- Depression/Anxiety
- Diabetes
- Drug Abuse
- Plantar Fasciitis
- Gout
- Cancer ____________
- COPD
- Hepatitis (A) (B) (C)
- Kidney
- Aching Feet
- Seizures
- Ulcers
- Smoker – Current or Former

Other Health Problems:

____
____
____

SURGICAL HISTORY

- Carpal Tunnel
- Gallbladder
- Appendix
- Shoulder
- Ankle
- Knee
- Hip
- Pacemaker
- Stent
- Cardiac (Heart)
- Back
- Thyroid
- Hernia
- Vascular
- Foot Surgery

Other Surgeries:

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