Patient Medical History

Who is your **primary care doctor** (PCP/PCM)? _____

Have you ever seen a Podiatrist before? Y / N If yes…who? _____

Do you have **allergies** to any medications? If so, please list:

_____

What **pharmacy** do you use (including location)?_____

Are you **currently** being treated for anything by another doctor? (diabetes, cancer, arthritis, high blood pressure, heart failure, etc)

_____

_____

_____

Please list ALL **surgeries** with the corresponding dates:

_____

_____

_____

Please list ALL **medications** that you are currently taking (or provide a personal list for your chart):

_____

_____

_____

Do you **use** the following: **Tobacco** Yes / No **Alcohol** Yes / No **Drugs** Yes / No

Marital Status: Single Married Separated Divorced Widowed

Is there a **family history** of any type of illness? (high blood pressure, diabetes, cancer, psoriasis, etc)

_____

_____

_____

Describe the **reason for your appointment** today. Be as **specific** as possible.

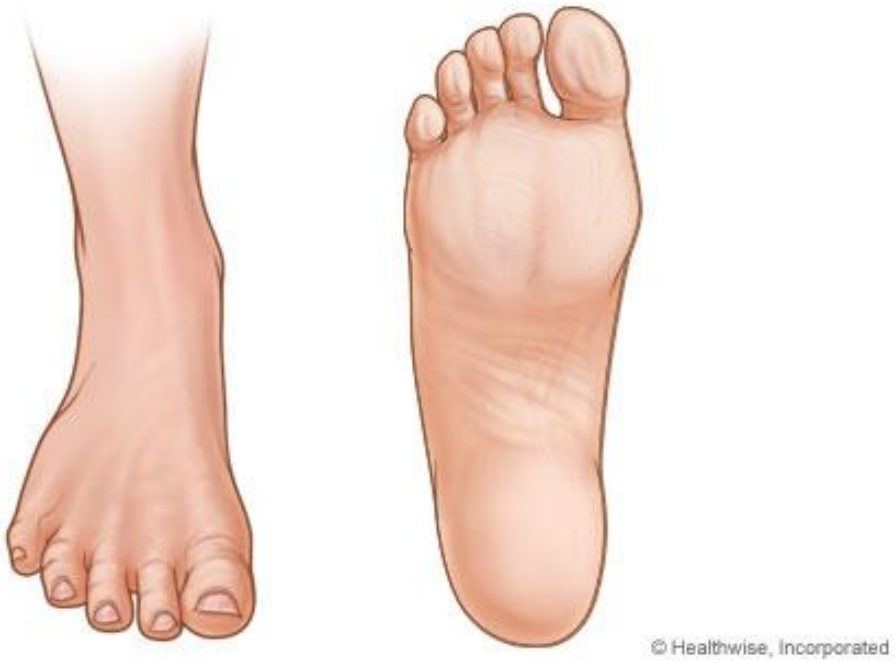
_____

_____

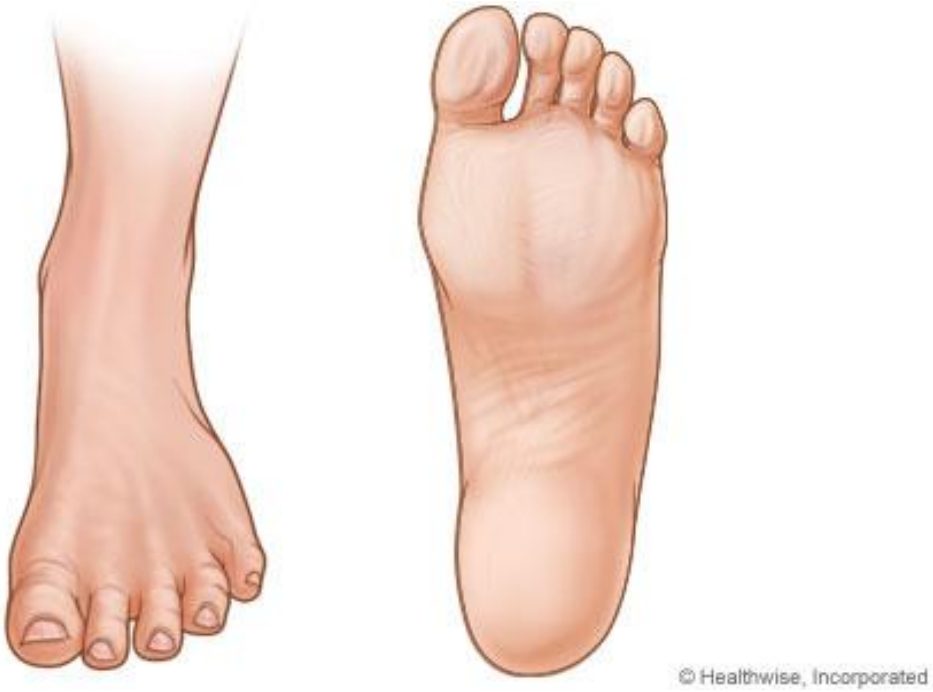
_____

Please indicate areas of pain or concern.

RIGHT FOOT



LEFT FOOT



Patient Demographics

Full Name: _____

Preferred Name (if different): _____

DOB: _____ Sex: Male / Female

Social Security Number: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Physical Address (if different): _____

City: _____ State: _____ Zip: _____

Primary Phone #: _____ Secondary Phone #: _____

Employer: _____

Email Address: _____

Emergency/Alternate Contact: _____

Phone Number: _____

Parent/Legal Guardian

Name: _____

Relationship to Patient: _____

DOB: _____ Sex: Male / Female

Social Security Number: _____

Mailing Address (if different): _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Alternate Phone: _____

Patient Insurance Information

Primary Insurance: _____

Member ID (or sponsor SSN): _____ Group #: _____

Policy Holder's Name: _____

Policy Holder's DOB: _____ Policy Holder's SSN: _____

Secondary Insurance: _____

Member ID (or sponsor SSN): _____ Group #: _____

Policy Holder's Name: _____

Policy Holder's DOB: _____ Policy Holder's SSN: _____

Tertiary Insurance: _____

Member ID (or sponsor SSN): _____ Group #: _____

Policy Holder's Name: _____

Policy Holder's DOB: _____ Policy Holder's SSN: _____

Credit Cards Accepted → VISA, MasterCard, Discover, American Express

****All copays are due at the time of service.**

By signing, I attest that all of the information provided is true and complete and that my injury/illness is not work related (worker's compensation). I authorize the release of any necessary information and payment of medical benefits to Ledger Foot and Ankle Clinic for services rendered. I understand and agree that: **1)** I am fully responsible for all charges to me including the balance remaining after payment of insurance benefits (as per insurance contracts). **2)** The responsible party is responsible for insurance referrals. **3)** A $25.00 fee will be charged on each returned check. **4)** Payment is expected on the day services are rendered unless prior arrangements have been made. **5)** Any returned check to our office will result in a cash only payment for future appointments. **6)** The information in this paragraph may not be altered or amended by me.

_____

Patient (or Responsible Party) Signature

Notice of Privacy Practices

I acknowledge that I was provided with, and have reviewed the **Notice of Privacy Practices** at *Ledger Foot & Ankle Clinic* and I understand that I may request a copy of this for my records.

Patient Name (print): _____

Patient (or Responsible Party) Signature: _____

Date: _____

I authorize *Ledger Foot & Ankle Clinic* to discuss my information with the following individual: (If **Medical Power of Attorney** applies, please provide a copy for the patient's chart.)

Name (print): _____

Relationship to Patient: _____

****

Documentation of Good Faith Effort

Office Use Only

_____ Attempted to distribute the **Notice of Privacy Practices** to the patient/personal representative but individual declined to acknowledge receipt.

_____ Patient/personal representative stated that he or she has already received the **Notice of Privacy Practices** from another source.

_____ Patient/personal representative has read and understands the **Notice of Privacy Practices**.

_____ _____

Employee Signature **Date**

Office Policies and Procedures

1. There will be a $20.00 no show fee charged to the patient for any missed appointment. Our office makes a point to call patients to remind them of upcoming appointments.
2. If you do not show up for your appointment on 3 consecutive occasions you will be notified by mail of your discharge as a patient of our clinic and you will be given 30 days to look for another podiatrist.
3. There is a charge of $1.00 per page for **printed** medical records not to exceed $20.00. However, if your records are requested by a physician involved in your care no fee will be applied. These records will be mailed or faxed to the requesting provider.
4. There is a $20.00 fee for any letter, paperwork, or documents requested by the patient. There is a 1 week turn around period for these to be picked up.
5. There is a 24-48 hour turn around period for all prescriptions to be picked up or called in to the pharmacy of your choice.
6. All co-pays are due at check-in and before being seen by the doctor. Any fees other than co-pays are also due upon check-in.
7. Any returned check to our office will result in cash only payments in the future.

I have read and understand the above policies and procedures for *Ledger Foot and Ankle Clinic*.

_____ _____

Patient Name (print) Patient (or Responsible Party) Signature