



PATIENT INFORMATION

Patient _____
Last Name First Name Middle Initial

Address _____
Street P.O. Box

_____ City State Zip

Mark the preferred **contact number**:

Home (_____) _____ **Work** (_____) _____

Cell (_____) _____

E-mail _____

*Used for appointment reminders, newsletters, billing inquiries and the Patient Portal.

Marital Status: Single Married
 Widowed Divorced

Sex: M F **Age** _____ **Birth Date** _____
MM/DD/YYYY

Social Security Number _____
*Required: Medicare, Medicaid, or Military

Preferred Language? _____

Ethnicity or Race:
 Hispanic/Latino American Indian/Alaska Native
 Asian Black or African American
 Native Hawaiian or other Pacific Islander
 White Other race

Occupation _____

Employer _____

Spouse's Name _____

Spouse's Employer _____

BILLING ADDRESS (If different than above)

_____ Street P.O. Box

_____ City State Zip

EMERGENCY CONTACT (Not in your household)

Name _____

Relationship _____

Home (_____) _____

Cell (_____) _____

RESPONSIBLE PARTY (For Minors)

Name _____ **DOB** _____

Relationship to Insured _____

Phone (_____) _____

Cell (_____) _____

PHYSICAL INFORMATION

Height _____ **Weight** _____

Shoe Size _____

Do You Have Diabetes?
 Yes No

If you have Diabetes, fill out the following questions?

Last A1c _____

Last Blood Sugar Reading _____

MEDICATIONS

Do you presently take any medications? Yes No

If yes, please list all current medications; include prescriptions, over-the-counter, herbs and vitamins.

Do you take oral contraceptives? Yes No

ALLERGIES

No Known Drug Allergies
 Adhesive Tape Local Anesthetic
 Anticoagulant Novocaine
 Aspirin Penicillin
 Codeine Sea Foods
 Latex Sulfa
 Iodine
 Other _____

PREFERRED PHARMACY

Pharmacy Name _____

Address _____

City, State _____

Phone _____

SOCIAL HISTORY

Do you exercise? No Seldom 1-3 times a week 3-5 times a week 6+ times a week

Do you drink alcohol? Yes No

Tobacco Use: **NON-SMOKER**

Never Smoked

Former Smoker

How many years? _____

SMOKER

Pick the one that best applies

Current Every Day Smoker

Current Some Day Smoker

Heavy Tobacco Smoker

Light Tobacco Smoker

How many years? _____

Pick the one that best applies

Smoked Per Day:

Less than 1 20 to 30

1 to 9

40 or more

10 to 19

SURGICAL HISTORY

Have you had a surgery? Never Yes (*fill in the rest of the section*)

List any **surgeries** you have had _____

Have you ever had an **infection** after surgery? Yes No If yes, please explain _____

Have you had any **complications** from surgery? Yes No If yes, please explain _____

List any **hospitalizations** other than the surgeries listed _____

BLOOD FAMILY HISTORY

	Mother	Father	Sister	Brother	Daughter	Son
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Complications from Anesthesia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dementia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Depression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes - Type I /Type II	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Obesity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Substance Abuse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

	Mother	Father	Sister	Brother	Daughter	Son
Breast Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Colon Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lung Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Skin Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stomach Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ovarian Cancer	<input type="checkbox"/>	--	<input type="checkbox"/>	--	<input type="checkbox"/>	--
Uterine Cancer	<input type="checkbox"/>	--	<input type="checkbox"/>	--	<input type="checkbox"/>	--
Prostate Cancer	<input type="checkbox"/>	<input type="checkbox"/>	--	<input type="checkbox"/>	--	<input type="checkbox"/>
Testicular Cancer	--	<input type="checkbox"/>	--	<input type="checkbox"/>	--	<input type="checkbox"/>

PODIATRIC HISTORY

What is the chief reason for being seen today? _____

Is this condition the result of an on the job injury? Yes No

If yes, please explain _____

Which foot/ankle? Right Left Both

Quality of ailment: *(Mark all that apply)*

- | | | | | | | |
|-------------------------------------|-----------------------------------|---------------------------------------|-----------------------------------|--|---------------------------------|---------------------------------------|
| <input type="checkbox"/> Aching | <input type="checkbox"/> Burning | <input type="checkbox"/> Constant | <input type="checkbox"/> Crushing | <input type="checkbox"/> Disabling | <input type="checkbox"/> Dull | <input type="checkbox"/> Inconsistent |
| <input type="checkbox"/> Sharp | <input type="checkbox"/> Pulling | <input type="checkbox"/> Stabbing | <input type="checkbox"/> Shooting | <input type="checkbox"/> Radiating | <input type="checkbox"/> Tender | <input type="checkbox"/> Throbbing |
| <input type="checkbox"/> Nauseating | <input type="checkbox"/> Tingling | <input type="checkbox"/> Pins/needles | <input type="checkbox"/> Swelling | <input type="checkbox"/> Pain after rest | | |

How long this condition has been present: _____ Days _____ Weeks _____ Months _____ Years

Severity of ailment: *(Mark all that apply)*

- Getting Better Stays the Same Getting Worse Mild Moderate Severe

Timing of onset: *(Mark all that apply)*

- Gradual Sudden Unknown Primarily at night With exercise
 After: _____ Associated with: _____

How did ailment start: *(Mark all that apply)*

- No Trauma Blunt Injury Cut from Sharp Object Auto Accident Trip or Fall
 Improper Foot Gear Sports Related Injury Other _____

What treatments, if any, you have tried: *(Mark all that apply)*

- None Change / Modify Shoe Gear Physical Therapy NSAID's X-Ray
 Orthotics / Arch Support Surgery Antibiotics Other _____

Have you ever seen a Podiatrist before? Yes No

If yes, please list name _____ Last Visit _____

MEDICAL HISTORY

Primary Care Physician: _____ **Last Visit Date:** _____

Are you now or have you been under the care of a physician during the past two years? Yes No

Have you ever had any of the following: Please mark "Yes"

- | | | | | | |
|---------------------------|------------------------------|-------------------------|------------------------------|------------------------|------------------------------|
| Cardiovascular Problem | <input type="checkbox"/> Yes | Hepatitis | <input type="checkbox"/> Yes | Artificial Joint | <input type="checkbox"/> Yes |
| Angina | <input type="checkbox"/> Yes | Kidney Disease | <input type="checkbox"/> Yes | Degenerative Arthritis | <input type="checkbox"/> Yes |
| Heart Attack | <input type="checkbox"/> Yes | Liver Disease | <input type="checkbox"/> Yes | Rheumatoid Arthritis | <input type="checkbox"/> Yes |
| Heart Disease | <input type="checkbox"/> Yes | Nose/Throat Problem | <input type="checkbox"/> Yes | Osteoarthritis | <input type="checkbox"/> Yes |
| Congest. Heart Failure | <input type="checkbox"/> Yes | Hearing Loss | <input type="checkbox"/> Yes | Gout | <input type="checkbox"/> Yes |
| Blood Clots/DVT | <input type="checkbox"/> Yes | Macular Degeneration | <input type="checkbox"/> Yes | Back Pain | <input type="checkbox"/> Yes |
| High Blood Pressure | <input type="checkbox"/> Yes | Retinopathy | <input type="checkbox"/> Yes | Fibromyalgia | <input type="checkbox"/> Yes |
| Artificial Heart Valves | <input type="checkbox"/> Yes | Blindness | <input type="checkbox"/> Yes | Osteomyelitis | <input type="checkbox"/> Yes |
| Heart Murmur | <input type="checkbox"/> Yes | Bleeding Disorder | <input type="checkbox"/> Yes | Neurological Disorder | <input type="checkbox"/> Yes |
| Skin Disorders | <input type="checkbox"/> Yes | High Cholesterol | <input type="checkbox"/> Yes | Neuropathy | <input type="checkbox"/> Yes |
| Cellulitis/Skin Infection | <input type="checkbox"/> Yes | Immunologic Disorder | <input type="checkbox"/> Yes | Sciatica | <input type="checkbox"/> Yes |
| Large Scars | <input type="checkbox"/> Yes | AIDS/HIV | <input type="checkbox"/> Yes | Seizure Disorder | <input type="checkbox"/> Yes |
| Slow Healing Sores | <input type="checkbox"/> Yes | Anaphylactic Reaction | <input type="checkbox"/> Yes | Stroke | <input type="checkbox"/> Yes |
| Endocrine Disorders | <input type="checkbox"/> Yes | Lupus | <input type="checkbox"/> Yes | Depression | <input type="checkbox"/> Yes |
| Diabetes | | Tuberculosis | <input type="checkbox"/> Yes | Chemical Dependency | <input type="checkbox"/> Yes |
| Type 1 | <input type="checkbox"/> Yes | Swollen Lymph Nodes | <input type="checkbox"/> Yes | Respiratory Disorder | <input type="checkbox"/> Yes |
| Type 2 | <input type="checkbox"/> Yes | Venereal Disease | <input type="checkbox"/> Yes | Asthma | <input type="checkbox"/> Yes |
| Hypothyroidism | <input type="checkbox"/> Yes | Rheumatic Fever | <input type="checkbox"/> Yes | Pulmonary Embolism | <input type="checkbox"/> Yes |
| Stomach/Bowel Cond. | <input type="checkbox"/> Yes | Musculoskeletal Disord. | <input type="checkbox"/> Yes | Shortness of Breath | <input type="checkbox"/> Yes |
| GI Bleed/Ulceration | <input type="checkbox"/> Yes | | | Cancer | <input type="checkbox"/> Yes |

Other Medical History _____

HOW DID YOU HEAR ABOUT US?

Dr. Referral (please give doctors name or office) _____

Employee Referral (please give the employee name) _____

Patient Referral (please give the patient name) _____

Other (please specify) _____

Google Search

Facebook Ad/Video

Insurance Referral

AFAC Website

CONSENT OF RELEASE

In my absence, I authorize AFAC to release all or portions of my or my dependents medical records to those as indicated below. This authorization is in effect until I revoke it in writing.

Name: _____

Name: _____

Name: _____

Name: _____

X _____

Signature of Patient or Parent/Authorized Representative

_____ Date

HIPPA NOTICE OF PRIVACY PRACTICES

I acknowledge that, upon request, I was provided access to a copy of the **Notice of Privacy Practices** and that I have read (or had the opportunity to read if I so choose) and understand the notice.

X _____

Signature of Patient or Parent/Authorized Representative

_____ Date

Print Name

ASSIGNMENT, RELEASE AND CONSENT

I request that payment of authorized insurance benefits be made either to me or on my behalf to AFAC for any service furnished. I authorize the release of medical information about me needed to determine these benefits or the benefits payable for related services. I understand that my signature requests that payment be made and authorizes the release of medical information necessary to pay the claim.

I understand that I am financially responsible for all charges whether or not paid by insurance. A financial fee of 1.5% per month will be added to all accounts past due. Delinquent accounts over 90 days past due will automatically be sent to a collection agency. Should collections become necessary the responsible party agrees to pay an additional 25% collection fee and all legal fees, with or without suit including attorney fees and court costs. If I have opted out of receiving a final notice for delinquent accounts by text or email below, I understand a letter via certified mail or priority mail will be sent. In sending this letter, a fee of up to \$6.00 will be added on top of the additional collection fee mentioned above. In *Medicare assigned cases*, the physician agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and non-covered services.

I understand that I may be billed a \$25 no-show fee for appointments that I miss without cancelling or rescheduling at least 24 hours in advance.

I certify that the above information is true and correct to the best of my knowledge. I hereby give my permission to AFAC to administer and perform such procedures and tests as may be deemed necessary in the diagnosis and treatment of my feet/ankles. I authorize the use of photography for documentation and/or educational purposes.

X _____

Signature of Patient or Parent/Authorized Representative

_____ Date

We want to stay in touch with you regarding your account and its collection status regarding past due balances. In order for us to contact you regarding all past due accounts and any collection status they may have, you expressly authorize us to contact you by the telephone by sending text messages or e-mails at any number or email you have listed. You acknowledge that such contact could result in charges to you by your telephone carrier. Methods of contact may include the use of pre-recorded/artificial voice messages and/or the use of an automatic telephone dialing system, as applicable. You acknowledge and agree that this authorization shall extend to any billing or collection company or companies which may be assigned.

Yes, I authorize this (initials) _____

No, I do not authorize this (initials) _____