Last Name _____ First Name _____ Middle Initial _____

**Date of Birth** _____**Height** _____ **Weight** _____**Shoe Size** _____ **Shoe Width** _____

Address: _____
City: _____ State: _____ Zip: _____
Sex: _____ M _____ F

FOOT AND ANKLE MEDICAL GROUP

**Phone Number** (_____) _____

**Email Address** _____

**Occupation:** _____

**What condition brought you into the office**? _____
How did you find out about us? _____

**In case of an emergency who should we notify**? _____
**Phone** (_____) _____

**Primary Care Physician**_____

**Pharmacy Name** _____ Pharmacy Phone _____

**Circle illnesses that you have had, then date Personal History:**

| | | |
|---|---|---|
| Mumps | Pneumonia | Stomach/Ulcers |
| Chicken Pox | Tuberculosis | Intestinal Problems |
| Measles | Asthma | Hepatitis/Liver |
| Whooping | Bronchitis | Kidney Disease |
| Cough | Emphysema | Thyroid Disease |
| Scarlet | Pleurisy | Bladder/Cystitis |
| Fever | Stroke | Recent Infections |
| Smallpox/Polio | Gout | Blood Problems |
| Hypertension | Arthritis | Seizures |
| Diabetes | Cancer | Phlebitis/Blood Clot |
| (Hemaglobin A1c) | Heart Disease | Auto Immune Disease |
| Venereal Disease | Rheumatic Fever | (Specify type)_____ |

Women - Are you pregnant? Yes _____ No _____

**Please List All Medication that you are currently taking:**

| Name of Medication | Dosage and frequency | Used for |
|---|---|---|
| | | |
| | | |
| | | |

**List All Surgical Operations, Hospitalizations or Injuries:**

_____
_____
_____

**Allergies, Check ☑ the following:** **I have no known allergies** ( )

**Aspirin** ( ) **Penicillin** ( ) **Iodine** ( ) **Codeine** ( ) **Sulfa Drugs** ( ) **Local Anesthetics** ( ) **Adhesive Tape** ( )
**Other** _____

**Family History: Age, Health, Illnesses**
Familial History of Foot Problems _____
Familial History of Anesthetic Reactions
_____
Parents/Siblings _____

**Social History:**
Tobacco: Years _____ Packs/day _____
Alcohol _____
Recreational substance _____

**PRIVATE PAY ACKNOWLEDGEMENT**
**ONLY If Insurance Is NOT Being Used**

Thank you for choosing The Foot and Ankle Medical Group for your care. Please be aware that your office visit is considered a **private pay, out-of-pocket service for elective procedures and treatments**. This means that the fees for the consultation are due at the time of your appointment and are not covered by insurance.

Please note that the cost of the office visit does not include any additional diagnostic tests, treatments, or procedures. If these **elective services** are recommended during your visit, they will be charged separately **as out-of-pocket expenses**. You will be informed of any additional charges before services are rendered.

A holder of this medical debt contract is prohibited by Section 1785.27 of the Civil Code from furnishing any information related to this debt to a consumer credit reporting agency. In addition to any other penalties allowed by law, if a person knowingly violates that section by furnishing information regarding this debt to a consumer credit reporting agency, the debt shall be void and unenforceable.

**Signature:**_____

**INSURANCE BILLING**

I certify that I, and/or my dependent(s), have insurance coverage with (**Name of Insurance Company(ies))** _____and assign directly to **Dr.** _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____ _____

**Signature of Patient, Parent, Guardian or Personal Representative** **Date**

_____ **Please print name of**

**Patient, Parent, Guardian or Personal Representative** **Relationship to Patient**

**ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF HIPAA PRIVACY PRACTICE GUIIDELINES**

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient rights section describing your rights under the law. The terms of our Notice may change. You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement. By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations.

You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA). The patient understands that:

- Protected health information may be disclosed or used for treatment, Payment or health care operations
- The Practice has a Notice of Privacy Practices, and that the patient has the opportunity to review this Notice
- The Practice reserves the right to change the Notice of Privacy Policies
- The patient has the right to restrict the uses of their information, but the Practice does not have to agree to those restrictions
- The patient may revoke this Consent in writing at any time and all future disclosures wiD then cease
- The Practice may condition treatment upon the execution of this Consent

Patient's Name (print) _____

Signature _____ Date _____/_____/_____

Relationship to Patient (if other than patient): _____