Welcome to Centennial Foot and Ankle

Please complete this form upon your first visit and sign. Notify us at future visits if any of the information changes.

DATE _____ REFERRED BY _____

PATIENT'S FIRST NAME _____ MI _____ LAST NAME_____

BIRTHDATE _____MALE ____ FEMALE____ SOCIAL SECURITY NUMBER _____

EMAIL ADDRESS_____

MAILING ADDRESS _____
STREET ADDRESS APT/UNIT# CITY STATE/ZIP

HOME PHONE _____ _____ CELL PHONE _____ PREFERRED NUMBER _____

MARITAL STATUS: SINGLE _____ MARRIED_____ PARTNER_____ WIDOWED____

PATIENT'S OR PARENT'S EMPLOYER _____ WORK PHONE _____

EMPLOYER ADDRESS _____ OCCUPATION _____

SPOUSE OR PARENT'S NAME _____

EMERGENCY CONTACT NAME _____ __ RELATIONSHIP _____ PHONE _____

NAME OF PRIMARY CARE DOCTOR _____ DATE OF LAST VISIT _____

WOULD YOU ALLOW OUR OFFICE TO SEND CLINICAL NOTES TO THIS PHYSICIAN YES ____ NO_____

INSURANCE/PAYMENT INFORMATION

PRIMARY INSURANCE _____ PHONE NUMBER _____

ID# _____ GROUP# _____

POLICY HOLDER _____ POLICY HOLDERS DOB _____

POLICY HOLDERS SS# _____ RELATIONSHIP TO PATIENT _____

SECONDARY INSURANCE _____ PHONE NUMBER _____

ID# _____ GROUP# _____

POLICY HOLDER _____ POLICY HOLDERS DOB _____

POLICY HOLDERS SS# _____ RELATIONSHIP TO PATIENT _____

TERTIARY INSURANCE_____ ID# _____ POLICY HOLDER _____

POLICY HOLDERS DOB _____ RELATIONSHIP TO PATIENT _____

PHARMACY NAME _____ PHONE NUMBER _____

What is your complaint/reason for today's visit: _____

Have you received treatment for this issue? Yes ____ No ____ Date of unset? _____

Degree of Pain: 0-10? _____

Are you experiencing any of the following? **Circle all that apply**

Achilles Tendonitis	Chronic Swelling	Gout	Neuropathy feet	Tarsal Tunnel
Ankle Sprain	Corns/Calluses	Hammertoe Pain	Numbness	Tendonitis
Arthritis	Diabetic Foot Pain	Heel Pain	Plantar Fasciitis	Tingling Feet
Blisters	Flat Feet	Ingrown nails	PVD/PAD	Trauma to feet/ankles
Burning Feet	Fungal Infection	Joint Pain	Shin Splints	Ulcerations feet/legs
Bone Spur	Fracture foot/ankle	Nail Fungus	Skin discoloration	Plantar Warts
Unequal leg length	Bunion Pain	Ganglion Cyst	Neuroma	Sweaty Feet

Is your visit related to?

An accident? Yes ___No ___ An injury? Yes ___No ___ Workers Compensation? Yes ___No ___

If your answer is YES to the above, please describe how, when and where the accident/injury occurred:

_____

Worker's Comp: Was a C-4 form filled out? Yes ___No ___ Are you represented by a lawyer? Yes ___No

MEDICATIONS:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

ALLERGIES TO MEDICATION:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____

SURGERY HISTORY

_____

_____

_____

DO YOU HAVE ANY TYPE OF: METAL IMPLANTS __ PACEMAKER __

DEFIBRILLATOR __ PLATES/SCREWS/RODS __

PLEASE CIRCLE ANY OF THESE CONDITIONS YOU MAY HAVE OR HAVE HAD IN THE PAST:

Heart Disease Liver Disease Lumbar Spine Disorder High Blood Pressure Bowel Disease Headaches

High Cholesterol Cancer (past or present) Tuberculosis/TB Lung Disease Anemia

Muscle Disease Blood Clots Mental Health Problem Hypoglycemia (low glucose) Bleeding Tendency

Depression Thyroid Disease Stroke Chronic Skin Disease Stomach Disease Seizures

Sleep Apnea Nerve Impairment Kidney, Bladder, or Prostate Disease Joint Replacements

Back Issues COPD Multiple Sclerosis

Other_____

Are you currently pregnant? YES ___ NO ____

DIABETES: ARE YOU A DIABETIC? YES ___ NO____ LAST HbA1c _____

HEIGHT _____ WEIGHT_____

SOCIAL HISTORY:

1. DO YOU SMOKE? YES _____ NO _____ IF SO, FOR HOW LONG? _____
2. FORMER SMOKER? YES _____ NO _____
3. DO YOU USE ALCOHOL? YES _____ NO _____ QUANTITY? _____ PER _____
4. RECREATIONAL DRUG USE? YES _____ NO _____ CRACK/COCAINE _____HEROIN ___ MARIJUANA ____
   METHANPHETAMINES ___ OTHER ____
   FREQUENCY____ LAST USED? _____

PATIENT RESPONSIBILITY

1: Payment of deductibles, co-pays, co-ins, or cash services is expected at time of service. We accept Cash, Credit, and Care Credit. Those left unpaid will be sent to collections, and you will be responsible for the fee's accumulated from our collection company. Invoices are sent out every 30 days. Any bounced checks will carry a bounced check fee of $35.00.

2: Twenty-four (24) hour notice is required for cancellation of all appointments. Failure to cancel an appointment within this time frame or failure to show for a scheduled appointment will result is a $25.00 charge being added to your account.

3: There will be a fee of $20.00 for all Paperwork that needs to be filled out by the doctor. This includes any forms given by your Employers, Insurance Company, and/or disability insurance.

4: Having insurance is NO guarantee that services rendered will be paid for by your insurance. You will be billed for denied/non-covered/or unpaid services. It is ultimately the patient's responsibility to understand his/her insurance coverage and/or plans.

5: It is YOUR responsibility to know what doctors or facilities are covered by your insurance policy. You will be expected to pay any services not covered by your insurance.

6: Copies of all valid insurance cards are required in order for us to bill your insurance. If you do not have this at the time of your visit you may be requested to reschedule the visit until such time as you can provide proof of insurance coverage, or you may be asked to pay for your visit in full at the time of service.

7: If your insurance requires a referral from your PCP to see a specialist, it is YOUR responsibility to obtain this and provide our office with a copy. If you do not have a copy of your referral you may be asked to reschedule your visit until the referral is obtained or you may be asked to pay for services in full prior to seeing the doctor.

8: If your insurance company denied your claim because they need additional information from you or another one of your providers, it is YOUR responsibility to make sure your insurance company receives this information. If you do not provide this information to your insurance company and your claim remains denied, you will be expected to pay for these services.

9: Request for any/all medical records will be charged at $.60 cents a page and $3.00 for all X-ray images.

8) Re-billing Fee: I agree to pay a fee of $15 for every additional billing statement sent to me, after first statement, for which there will be no charge. This will be in effect, unless there is a prior payment arrangement made with Centennial Foot and Ankle.

OTHER PATIENT RESPONSIBILITY Photo I.D. required this our way of making sure we are treating the correct patient. If the patient is a minor we will require photo I.D. of a parent/guardian. If you cannot provide this information, we will need to reschedule your appointment.

Patient Name:

_____ Date: _____

Patient Signature:

_____

If patient is under 18, Parent or legal guardian to sign above