FAMILY FOOT & ANKLE CENTERS

ORTHOPEDIC INTAKE FORM

PATIENT INFORMATION

Last Name _____ First Name _____ MI _____ Sex ❒ M ❒ F

Date of Birth _____ Age _____ Social Security # _____

Address _____ City _____ Zip _____

Who can we thank for referring you/ how did you find us? _____

Family Physician _____ City _____ Date of Last Visit _____

Pharmacy _____ City _____

Height _____ Weight _____ Shoe Size _____

PHONE NUMBERS

Home Phone _____ Cell Phone _____

Email _____

In case of emergency, please contact:

Name _____ Phone _____

EMPLOYMENT

Name of Employer _____ City _____

At your job do you: ❒ sit mostly ❒ stand mostly ❒ sit and stand

Are you required to wear a specific type of shoe/ boot? _____

REVIEW OF SYSTEMS Please check all that apply

Nerve:	❒ Foot Burning ❒ Foot Numbness ❒ Seizure ❒ Loss of Balance
Skin:	❒ Rash ❒ Skin Sores ❒ Itching ❒ Dry Skin ❒ Toenail Changes
Orthopedic:	❒ Joint Pain ❒ Muscle Pain ❒ Leg Cramps ❒ Weakness ❒ Knee Pain ❒ Back Pain

REASON FOR VISIT

Reason for today's visit _____ How Long? _____

Severity of Pain or condition ❒ Mild ❒ Moderate ❒ Severe ❒ Severe at times

Type of pain (if painful) ❒ Sharp ❒ Dull ❒ Stabbing ❒ Aching ❒ Burning ❒ Other _____

This problem is ❒ Improving ❒ Worsening ❒ Unchanged

What makes it worse ❒ Activity ❒ Exercise ❒ Work ❒ Laying in Bed ❒ Other _____

What makes it better ❒ Rest ❒ Ice ❒ Heat ❒ Elevation ❒ Other _____

What treatments have you tried, if any? _____

MEDICAL HISTORY Please check the ones that apply

❒ AIDS / HIV
❒ Diabetes (Insulin)
❒ Diabetes (No Insulin)
❒ Arthritis
❒ High Blood Pressure
❒ Stroke (CVA)
❒ Heart Trouble
❒ Kidney Disease
❒ Lung Disease (COPD)
❒ Hepatitis (A, B, C)
❒ Stomach Problems
❒ Anxiety / Depression
❒ Gout
❒ Fibromyalgia
❒ Blood Clots
❒ Artificial Joints
❒ Cancer: _____

FINANCIAL POLICY

I give permission to Jeffrey S. Petty DPM, his associates or assistants to examine/treat me during the care of my condition. I understand that I am financially responsible for all charges, whether or not paid by insurance. The only limitation to my financial liability for charges not paid by insurance occurs in the event of contractual limitations to the charged fees that have been agreed upon by Jeffrey S. Petty, DPM, PA and the insurance company. I authorize use of this signature for all insurance claims (including Medicare/Medicaid if applicable).

Signature _____ *Date* _____

PFSH

Past Surgeries _____

Do you smoke tobacco? ❒ Yes ❒ No If yes, how many packs per day? _____

Do you drink alcohol? ❒ No ❒ Occasional ❒ Moderate ❒ Heavy

Circle all that apply. Family History of: Diabetes, Gout, Flat Feet, Ingrown Toenails, Bunions

MEDICATIONS

_____ Dosage _____ _____ Dosage _____
_____ Dosage _____ _____ Dosage _____
_____ Dosage _____ _____ Dosage _____

Allergies _____

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Name: _____ DOB: _____

Please Circle ALL Allergies:

CODEINE PENICILLIN SULFA TAPE LATEX CORTISONE IODINE SEASONAL

OTHER ALLERGIES: _____

_____

_____

_____

_____

_____

_____

- Do we have permission to look at your previous medication from other doctors and or pharmacies? _____Yes _____ No

_____ _____

Signature Date

Please give your insurance card and drivers license to the receptionist to be copied.

Insurance Information

Primary Insurance: _____

Policy # / Subscriber ID #: _____

Relationship: ( ) Self ( ) Spouse ( ) Other Relation _____

Name of Policy Holder: _____

Policy Holder Date of Birth: _____

Policy Holder Social Security #: _____

Secondary Insurance: _____

Member #/Subscriber ID #: _____

Relationship: ( ) Self ( ) Spouse ( ) Other Relation_____

Name of Policy Holder: _____

Policy Holder Date of Birth: _____

Policy Holder Social Security #: _____

I acknowledge that the above is true to the best of my knowledge. 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) as I so chose, and understand the notice.

_____ _____

Printed Name Date

_____ _____

Signature Parent or Authorized Representative (if applicable)

<u>INSURANCE PATIENTS ONLY</u> – (Please initial one & Sign Below)

_____ I understand that even though I am paying my copay or towards my deductible today that my insurance is being billed. I understand that I still may receive a bill and any remaining balances will be my full responsibility.

(Even if I have a secondary insurance.)

_____ I understand that my insurance is Out-of-Network – and even though I am paying my copay or towards my deductible today that my insurance is being billed out of network and my coinsurance could be higher. I understand that I still may receive a bill and any remaining balances will be my full responsibility.

_____ I understand that even though I have insurance – I have decided to opt out and pay as a self-pay cash patient. I understand that my insurance WILL NOT be billed and fees for services rendered must be paid today.

_____ _____

Signature **Date**

<u>NO INSURANCE – CASH PATIENTS</u> – (Please initial If NO Insurance & Sign Below)

_____ I understand that I do not have any insurance and as a cash patient all fees must be paid today for services rendered.

_____ _____

Signature **Date**

FAMILY
FOOT & ANKLE
CENTERS

CORSICANA
3229 W. 7th Ave.
Corsicana, TX 75110
903-872-9910

ENNIS
601 S. Clay St. Ste. 105
Ennis, TX 75119
972-875-3668

WAXAHACHIE
1505 W Jefferson Ste.
Waxahachie, TX 75165
972-597-4132

Medical Financial Consent Form

You agree, in order for us to service our account or to collect any amounts you may owe, our organization's representatives, ancillary providers, HIPAA business associates, vendors, and the representatives of our debt collection agency, may contact you by telephone at any telephone number associated with your account, including wireless telephone numbers, which could result in charges to you. Our organization's representatives, ancillary providers, HIPAA business associates, vendors, and the representatives of our debt collection agency may also contact you by sending text messages or emails, using any e-mail address you provide to us. Methods of contact may include using prerecorded/artificial voice messages and/or use of an automatic dialing device, as applicable. I/We have read this disclosure and agree that the Lender/Creditor, its ancillary providers, HIPAA business associates, vendors and its debt Collection agents may contact me/us as described above.

_____ _____

Borrower/Customer Signature Date

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CENTERS

FINANCIAL AGREEMENT

1. Services are rendered to the patient, not the insurance company. As a courtesy, our office will file your insurance if proper information is furnished.
    - You are responsible for co-pays, deductibles, non-covered services, co-insurance and items considered "not medically necessary" by your insurance company.
    - For unpaid claims over 45 days, it is your responsibility to follow up with your insurance and the balance due is considered due and payable.
2. It is your responsibility to notify our front desk staff of any insurance or address changes.
3. You will be responsible for any charges that occur if we are not notified.

PATIENT AUTHORIZATION

I hereby authorize Dr. Petty/Dr. Mankerious to administer such medication or procedures as are necessary on the basis of findings in my case. I authorize the holder of medical or other information to release to my insurance carrier, governmental agency or its intermediary any information needed for this or a related insurance claim. I request that payment of authorized benefits be made to **Corsicana Foot & Ankle/PMPT**, I agree to pay any charges incurred by me to **Corsicana Foot & Ankle/PMPT**. 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.

_____ I authorize **Corsicana Foot & Ankle/PMPT** to submit insurance claims using my signature on file below.

_____ I authorize the release of any medical information necessary in order to process this assignment on this claim.

_____ I authorize payment of medical benefits to be paid directly to **Corsicana Foot & Ankle/PMPT** for services described on the claim form.

ALL CO-PAYS AND/OR CO-INSURANCES ARE DUE AT THE TIME OF SERVICE UNLESS PREVIOUS ARRANGEMENTS HAVE BEEN MADE.

I authorize Dr. Petty/Dr. Mankerious to release any medical or billing information necessary for treatment, payment, or healthcare operations to the following healthcare professions, family, and/or friends:

_____	_____
Name	Relationship
_____	_____
Name	Relationship
_____	_____
Name	Relationship
_____	_____
Patient Signature (or authorized representative)	Date