

# FOOT AND ANKLE SPECIALISTS OF CENTRAL OHIO

Thank you for choosing our office! In order to serve you properly, we need ALL the following information. PLEASE PRINT. All information will be confidential.

Patient Name: \_\_\_\_\_ Social Security #: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
Home Phone #: \_\_\_\_\_ Cell Phone # \_\_\_\_\_ Work Phone # \_\_\_\_\_  
Preferred contact #: ( ) home ( ) cell ( ) work E-mail Address: \_\_\_\_\_  
Birth date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_\_ Sex: \_\_\_M \_\_\_F Marital Status: \_\_\_\_\_  
Employer: (If child is a minor parent/guardian's employer): \_\_\_\_\_  
Occupation: \_\_\_\_\_ If patient is student, name of school: \_\_\_\_\_

Person to contact in case of emergency: \_\_\_\_\_ Phone #: \_\_\_\_\_  
Relationship to you: \_\_\_\_\_ Whom may we thank for referring you: \_\_\_\_\_

## **RESPONSIBLE PARTY**

Name of person responsible for this account: \_\_\_\_\_ Relationship to patient: \_\_\_\_\_  
Address: \_\_\_\_\_ Home phone #: \_\_\_\_\_  
Employer: \_\_\_\_\_ Work phone #: \_\_\_\_\_

## **INSURANCE INFORMATION (MUST BE COMPLETED FULLY)**

**Primary insurance:** \_\_\_\_\_ ID# \_\_\_\_\_ Group # \_\_\_\_\_  
Name of insured: \_\_\_\_\_ Birth date: \_\_\_\_/\_\_\_\_/\_\_\_\_  
Social Security #: \_\_\_\_\_ Relationship to patient: \_\_\_\_\_ Work phone #: \_\_\_\_\_  
Employer: \_\_\_\_\_ Effective date of insurance: \_\_\_\_\_

**Secondary insurance:** \_\_\_\_\_ ID# \_\_\_\_\_ Group # \_\_\_\_\_  
Name of insured: \_\_\_\_\_ Birth date: \_\_\_\_/\_\_\_\_/\_\_\_\_  
Social Security #: \_\_\_\_\_ Relationship to patient: \_\_\_\_\_ Work phone #: \_\_\_\_\_  
Employer: \_\_\_\_\_ Effective date of insurance: \_\_\_\_\_

## **ASSIGNMENT AND RELEASE**

I, the undersigned certify that I (or my dependent) have insurance coverage with the above listed insurance company and assign directly to Foot and Ankle Specialists of Central Ohio, LLC 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 hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

RESPONSIBLE PARTY SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

## **MEDICARE AUTHORIZATION**

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Foot and Ankle Specialists of Central Ohio, LLC for any services furnished me. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier 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 noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

BENEFICIARY SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

## **PODIATRIC HISTORY**

What type of foot/ankle problem(s) are we seeing you for? \_\_\_\_\_

Have you ever been to a Podiatrist before?  Yes  No If yes Name: \_\_\_\_\_ Last visit: \_\_\_\_\_

Please indicate which foot problems you now have or have had in the past. (Please check all that apply)

Ankle Pain  Athlete's Foot  Bunions  Corns & Calluses  Numbness in legs or feet  Flat Feet  Heel Pain  
 Foot or Leg Cramps  Ingrown Toenails  Swelling in Ankles or Feet  Tired Feet  Plantar Warts

## **MEDICAL INFORMATION**

Family physician: \_\_\_\_\_ Last visit date: \_\_\_\_\_

Family physician address: \_\_\_\_\_ Phone #: \_\_\_\_\_

Please mark with a "Y" for yes, "N" for no, or "F" for family member if there is a history of the following:

<input type="checkbox"/> AIDS/HIV	<input type="checkbox"/> Ear Problems	<input type="checkbox"/> Radiation Treatment
<input type="checkbox"/> Allergies to Anesthetics	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Rash
<input type="checkbox"/> Allergies to Medicine or Drugs	<input type="checkbox"/> Eye Problems	<input type="checkbox"/> Respiratory Disease
<input type="checkbox"/> Anemia	<input type="checkbox"/> Fainting	<input type="checkbox"/> Rheumatic Fever
<input type="checkbox"/> Angina	<input type="checkbox"/> Gout	<input type="checkbox"/> Shortness of Breath
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Headaches	<input type="checkbox"/> Sinus Problems
<input type="checkbox"/> Artificial Heart Valves or Joints	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Special Diet
<input type="checkbox"/> Asthma	<input type="checkbox"/> Hemophilia	<input type="checkbox"/> Stroke
<input type="checkbox"/> Back Problems	<input type="checkbox"/> Hepatitis or Juandice	<input type="checkbox"/> Swollen Neck Glands
<input type="checkbox"/> Bleeding Disorders	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Cancer	<input type="checkbox"/> Kidney Problems	<input type="checkbox"/> Ulcers
<input type="checkbox"/> Chemical Dependency	<input type="checkbox"/> Liver Disease	<input type="checkbox"/> Varicose Veins
<input type="checkbox"/> Chest Pain	<input type="checkbox"/> Low Blood Pressure	<input type="checkbox"/> Venereal Disease
<input type="checkbox"/> Chronic Diarrhea	<input type="checkbox"/> Nervous Problems	<input type="checkbox"/> Weight Loss, unexplained
<input type="checkbox"/> Circulatory Problems	<input type="checkbox"/> Phlebitis	OTHER: _____
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Psychiatric Care	_____

**PLEASE LIST ANY MEDICATIONS WHICH YOUR ARE CURRENTLY TAKING:** \_\_\_\_\_

**ARE YOU ALLERGIC TO ANY MEDICATION OR LOCAL ANESTHETIC?**  YES  NO (If yes please check all that apply)

Adhesive/Tape  Aspirin  Codeine  Demerol  Iodine  Penicillin  Sulfa  Seafood  Novacaine  
 Local Anesthetics OTHER ALLERGIES NOT LISTED: \_\_\_\_\_

**PLEASE LIST WITH DATES ANY MAJOR OPERATIONS OR ILLNESS:** \_\_\_\_\_

## **SOCIAL HISTORY**

Are you a smoker?  Yes  No If yes how many packs a day \_\_\_\_\_ & # of years you have smoked: \_\_\_\_\_

Alcohol use?  None  Minimal  Moderate. Coffee use?  Yes  No. If yes how many cups per day \_\_\_\_\_

I CERTIFY THAT THE ABOVE INFORMATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE. I GIVE MY PERMISSION TO THE DOCTOR TO ADMINISTER AND PERFORM SUCH PROCEDURES AS MAY BE DEEMED NECESSARY IN THE DIAGNOSIS AND TREATMENT OF MY FOOT CONDITION.

PATIENT'S OR RESPONSIBLE PARTY SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_