PINNACLE FOOT & ANKLE CENTER

TODAY'S DATE: _____

PATIENT INFORMATION:
LAST NAME: _____ LEGAL FIRST NAME: _____ MI: ____
PREFERRED NAME: _____
SOCIAL SECURITY #: _____ AGE: _____ DOB: _____ GENDER: _____
MARITAL STATUS: _____ SPOUSE'S NAME: _____
ADDRESS: _____
CITY: _____ STATE: _____ ZIP CODE: _____
PHONE: _____ ALTERNATE PHONE: _____
EMAIL: _____
IF PATIENT IS A MINOR: PARENT(S) OR GUARDIAN(S) NAME: _____

PATIENT PLACE OF EMPLOYMENT: _____ PHONE: _____
POSITION: _____
EMERGENCY CONTACT NAME: _____ PHONE: _____
RELATIONSHIP: _____

INSURANCE INFORMATION:
PRIMARY INSURANCE: _____ POLICY #: _____ GROUP #: _____
SUBSCRIBER/POLICY HOLDER NAME: _____ DOB: _____ SOCIAL SECURITY #: _____
SECONDARY INSURANCE: _____ POLICY #: _____ GROUP #: _____
SUBSCRIBER/POLICY HOLDER NAME: _____ DOB: _____ SOCIAL SECURITY #: _____

YOUR MEDICAL TEAM:
PRIMARY CARE PHYSICIAN: _____ DATE OF LAST VISIT: _____
CARDIOLOGIST: _____
ENDOCRINOLOGIST: _____
NEPHROLOGIST: _____

HOW DID YOU HEAR ABOUT OUR OFFICE: _____

REASON FOR APPOINTMENT TODAY: _____ REFERRED BY: _____
IF APPOINTMENT DUE TO INJURY:
DATE OF INJURY: _____ AFFECTED/INJURED BODY PART AND SIDE: _____
XRAY OR MRI: _____ LOCATION OF TEST: _____
SHORT DESCRIPTION OF ACCIDENT/INJURY: _____
_____

PHARMACY: LOCAL: _____ LOCATION: _____
MAIL IN: _____

HEIGHT: _____ WEIGHT: _____ SHOE SIZE: _____

MEDICATIONS: NONE (circle if no medications or any type of vitamins/supplements)

Include ALL names of medication/vitamin/herbal/supplement, strength/dosage and frequency/how often taken/needed

PRESCRIPTION MEDICATIONS:

VITAMINS:

SUPPLEMENTS:

HERBALS:

OVER THE COUNTER:

PINNACLE FOOT & ANKLE CENTER

PATIENT AUTHORIZATION

I hereby give Pinnacle Foot & Ankle Center permission to examine and treat my feet. I authorize Pinnacle Foot & Ankle Center to submit any and all health care information to any health insurance program for their review and payment. I authorize payment of medical benefits to the practice. I further understand and agree to pay for services or amounts applied to my annual deductible, co-payments, as well as charges denied by my insurance program or considered not medically necessary. Examples of these denied charges may include injections, routine medical care not due to an illness or condition, and any other service specified in my health insurance contract.

_____ _____

Signature of patient (Parent or Guardian of Minor) Date

MEDICARE BENEFICIARIES

I request that payments made by Medicare be payable on my behalf to Pinnacle Foot & Ankle Center for any service(s) furnished to me by any of these physicians. I authorized any holder of medical information about me to be released to the Health Care Finance Administration and its agents of any information needed to determine these benefits payable to related services.

I understand my signature request that payment be made to Pinnacle Foot & Ankle Center and authorizes release of medical information necessary to pay the claim. If the appropriate item of the HCFA-1500 claim form is completed, my signature authorizes releasing of the information to the insurer for agency shown. 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 remaining amount between Medicare's payment and the Medicare allowed charge, any deductibles, co-insurance and non-covered services. Co-insurance and the deductible are based upon the charge determination of the Medicare carrier.

_____ _____

Signature Date

Financial Policy

We are pleased to provide your podiatric care. Please understand that payment is part of your treatment. The following is a statement of our Financial Policy, which you need to read and sign.
Patients or their legal representative shall complete an information sheet which requests current insurance information before seeing the doctor.

- If Self Pay, full payment is due at the time of service
- Co payments are due at the time of service
- Coinsurance amounts are due at the time of service
- If you have insurance, your claim will be sent to your insurance company and any remaining balance due after their portion is paid will be your responsibility
- We accept cash, checks, and major credit cards. Returned checks will be subject to a $25.00 fee

If you are unable to make timely payments due to financial hardship please contact our office for assistance with this matter.

REGARDING INSURANCE:

Your insurance is a contract between you and your insurance company. It is *your* responsibility to contact your insurance company to confirm network status of the physician prior to your visit. Should the doctor have an agreement with your insurance company, we will bill the insurance *if* it is a covered service.
Not all services are a covered benefit. It is *your* responsibility to check with your insurance company prior to your visit regarding what services will and will not be covered. If the service is a non-covered service you will be responsible for payment at the time of service.
If a patient is covered by both Medicare and Medicaid we will assume the patient is experiencing financial hardship in which case non-covered fees will be waived.
We are sure you have heard of "Identity Theft". As our practice continues to grow, it is one of our top priorities to keep our patients personal information safe. As a result we will need to review your insurance card at each visit.

MINOR PATIENTS:

The child's parent or guardian is responsible for payment at the time of service.

NEW PATIENTS:

New Patients are to arrive at the office 1 hour in advance of their appointment time to fill out necessary paperwork. If all of your paperwork is not completed by your appointment time, we reserve the right to reschedule you.

MISSED APPOINTMENTS:

As a courtesy, please contact our office to cancel an appointment a minimum of 24 hours in advance. If an established patient fails to show for three appointments without calling to cancel, the patient will be terminated. New patients failing to cancel their initial appointment will not be scheduled a second time. Missed appointments are subject to a fee.

ARRIVING LATE:

If you arrive 5 minutes late for your scheduled appointment time, we reserve the right to reschedule your appointment.

I, the patient or legal guardian, understand that by signing this form I accept full financial responsibility of this account.

_____ _____ _____

Signature of Patient, Parent or Guardian Relationship Date

PINNACLE FOOT & ANKLE CENTER

ACKNOWLEDGEMENT OF RECEIPT

I, _____, acknowledge that I have received the Notice of Privacy Practices issued by Pinnacle Foot & Ankle Center

I, _____, authorize Pinnacle Foot & Ankle Center to discuss my health information with the following persons:

List phone numbers with names

Spouse: _____

Children: _____

_____

Parent: _____

_____

Other: _____

_____ Check if you do not authorize anyone.

_____ _____

Signature of Patient or Guardian Date

PINNACLE FOOT & ANKLE CENTER

AGREEMENT OF PRESCRIPTION AND CONTROLLED SUBSTANCE CONTRACT

Patient Name: _____ DOB: _____

I agree to the following provisions to continue to receive controlled substance(s) for my condition. I have been informed of the potential dangers and risks associated with controlled medications use. I understand that compliance with the following guidelines is important to the continuation of treatment by my doctors. I also agree to comply with all my scheduled appointments. I will not request controlled substances or any other pain medication from prescribers other the doctor listed below.
I also agree to consent to random drug testing. Results of this testing may be released to other agencies if requested. I released the physician from any damages or liability failure to comply with testing may result in denial of prescription.

THE DO'S AND DON'TS EDUCATION HIGHLIGHTS

DO:
-Read the Medication Guide
-Take your medicine exactly as prescribed
-Store your medicine away from children and in a safe place
-Flush unused medicine down the toilet
-Call your healthcare provider for medical advice about side effects
-You may report side effects to the FDA at 1-800-FDA-1088
-Call 911 or your local emergency service immediately if you take too much medicine, have trouble breathing or shortness of breath
-Call 911 if a child has taken this medicine

DON'T:
-Do not give your medicine to others
-Do not take medicine unless it was prescribed to you
-Do not stop taking your medicine without talking to your healthcare provider
-Do not break, chew, crush, dissolve or inject your medicine. If you cannot swallow your medicine whole talk to your healthcare provider
-Do not drink alcohol while taking this medicine

TALK TO YOUR HEALTHCARE PROVIDER:
-If the dose you are taking does not control your pain
-About any side effects you may be having
-About all medicines you take including over the counter medicines, vitamins and dietary supplements

I understand that failing to follow this agreement may result in discontinuation of all narcotic or controlled substance prescriptions being prescribed from this provider and could potentially result in care being terminated by the physician listed below.

I have read and understand the agreement.

ARE YOU CURRENTLY A PATIENT AT A PAIN CLINIC? YES ___ NO ____ IF YES- WHERE? _____
(I understand that it is my responsibility to inform Pinnacle Foot & Ankle Center if I become a patient of a pain clinic in the future)

_____ _____
Signature of patient, parent or legal guardian Date

_____ _____
Pinnacle Foot & Ankle Center physician Date

Do not write, stamp, punch holes or affix a sticker in this area.

Review of Systems

Please answer every question

To reproduce, follow the printing instructions. Do not fold this form.

PLEASE PRINT PATIENT'S LAST NAME

Marking Instructions

Please use a # 2 pencil
Fill in the complete oval as shown...

PLEASE PRINT PATIENT'S FIRST NAME

PATIENT'S DATE OF BIRTH

Month Day Year

FIRST VISIT Mark all symptoms that pertain to you.
REPEAT VISIT Mark only the symptoms that you have experienced since your last visit.
Mark all that apply ---- if no symptoms, please mark "NONE."

General			
chills	weight loss	night sweats	
fever	weight gain	appetite loss	
excessive perspiration	feeling sick	fatigue	NONE
Eyes			
double vision	"halos" around lights	discharge	
vision loss - 1 eye	blurring	eye irritation	
vision loss – both	light sensitivity	eye pain	NONE
Ear, Nose, and Throat	earache	ringing in ears	
ear discharge	nosebleeds	hoarseness	
decreased hearing	nasal congestion	sore throat	NONE
Cardiovascular			
		shortness of breath with exertion	
swelling of hands or feet	leg cramps with exertion	bluish discoloration of lips or nails	
chest pain or discomfort	difficulty breathing lying down	racing / skipping heartbeats	NONE
Respiratory			
excessive sputum	cough	sleep disturbances due to breathing	
wheezing	excessive snoring	coughing up blood	NONE
Gastrointestinal			
	excessive appetite	nausea	
gas	indigestion	diarrhea	
vomiting	constipation	difficulty swallowing	
vomiting blood	yellowish skin color	dark tarry stools	
abdominal pain	change in bowel habits	bloody stools	NONE
Genitourinary			
painful urination	trouble starting urinary stream	pelvic pain	
blood in urine	inability to empty bladder	genital sores	
urinary urgency	inability to control bladder	missed periods	
urinary frequency	night time urination	excessively heavy periods	NONE
Musculoskeletal		muscle cramps	
joint pain	stiffness	muscle weakness	
joint swelling	back pain	muscle aches	NONE
Skin		rash	
itching	suspicious lesions	changes in color of skin	
dryness	poor wound healing	changes in nail beds	NONE
Neurologic			
headaches	falling down	tingling	
poor balance	fainting	disturbances in coordination	
numbness	memory loss	difficulty with concentration	
tremors	weakness	sensation of room spinning	NONE
Psychiatric	anxiety	depression	NONE
Endocrine			
	heat intolerance	excessive thirst	
cold intolerance	excessive hunger	excessive urination	NONE
Heme / Lymphatic		abnormal bruising	
bleeding	skin discoloration	enlarged lymph nodes	NONE
Allergic / Immunologic			
persistent infections	seasonal allergies	HIV exposure	NONE

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Surgeries

Please answer every question

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PLEASE PRINT PATIENT'S LAST NAME

PLEASE PRINT PATIENT'S FIRST NAME

PATIENT'S DATE OF BIRTH

Month Day Year

Marking Instructions

Please use a # 2 pencil
Fill in the complete oval as shown...

Please mark all surgeries you have had.

◯ I have had no Surgeries. (no need to complete questionnaire)

◯ **Anal Fissure Repair**
◯ **Appendectomy**
◯ **Hemorrhoidectomy**
◯ **Low Back Disc Surgery**
◯ **Neck Disc Surgery**
◯ **Sinus Surgery**
◯ **Tonsillectomy**
◯ **Ulcer Surgery**
◯ **Vasectomy**
◯ **Deviated Nose Septum**
◯ **Tubal Ligation**

Prostate Surgery	◯ TURP	◯ Removal		
Gallbladder Surgery	◯ Open	◯ Laparoscopic		
Colon Polyp Removal	◯ Open	◯ Colonoscopy		
Colon Removal	◯ Partial	◯ Complete		
Hysterectomy (due to cancer)	◯ Partial	◯ Complete		
Hysterectomy (not due to cancer)	◯ Partial	◯ Complete		
Spinal Fusion	◯ Neck	◯ Lower Back		
Spinal Decompression	◯ Neck	◯ Lower Back		
Dilation and Curettage (D&C)	◯ Single	◯ Multiple		
Lung Surgery	◯ Left	◯ Right	◯ Both	
Kidney Removal	◯ Left	◯ Right	◯ Both	
Cataract Surgery	◯ Left	◯ Right	◯ Both	
Breast Cancer Lump Removal	◯ Left	◯ Right	◯ Both	
Mastectomy	◯ Left	◯ Right	◯ Both	
Breast Reconstruction	◯ Left	◯ Right	◯ Both	
Breast Reduction	◯ Left	◯ Right	◯ Both	
Ovary Removal	◯ Left	◯ Right	◯ Both	
Carpal Tunnel Surgery	◯ Left	◯ Right	◯ Both	
Rotator Cuff Repair	◯ Left	◯ Right	◯ Both	
Arthroscopic Shoulder Surgery	◯ Left	◯ Right	◯ Both	
Hip Fracture & Surgery	◯ Left	◯ Right	◯ Both	
Total Hip Replacement	◯ Left	◯ Right	◯ Both	
Total Knee Replacement	◯ Left	◯ Right	◯ Both	
Arthroscopic Knee Surgery	◯ Left	◯ Right	◯ Both	
Foot Surgery	◯ Left	◯ Right	◯ Both	
Leg Circulation Surgery	◯ Left	◯ Right	◯ Both	
Mastoidectomy	◯ Left	◯ Right	◯ Both	
Thyroid Removal	◯ Left	◯ Right	◯ Total	◯ Partial
Breast Biopsy	◯ Left	◯ Right	◯ Both	◯ Multiple times
Carotid Artery Surgery	◯ Left	◯ Right	◯ Both	◯ Multiple times
Open Inguinal Hernia Surgery	◯ Left	◯ Right	◯ Both	◯ Multiple times
Laparoscopic Inguinal Hernia Surgery	◯ Left	◯ Right	◯ Both	◯ Multiple times
Caesarean Section	◯ 1	◯ 2	◯ 3 or more	
Heart Valve Replacement	◯ Mitral	◯ Aortic	◯ Tricuspid	◯ Unknown Valve
Heart Bypass Surgery	◯ 1 vessel	◯ 2 vessels	◯ 3 vessels	◯ 4 or more vessels
	◯ Unknown number of vessels			
Other Surgery	◯			

Do not write, stamp, punch holes or affix a sticker in this area.

Personal / Family History

Please answer every question

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PLEASE PRINT PATIENT'S LAST NAME

PLEASE PRINT PATIENT'S FIRST NAME

PATIENT'S DATE OF BIRTH

Month Day Year

Marking Instructions

Please use a #2 pencil.
Fill in the complete oval as shown...

TOBACCO USE

What is your smoking status? current (every day) ○ current (some days) ○ previous ○ never ○

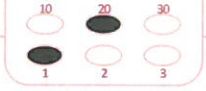
At what age did you begin smoking?

If you quit smoking, at what age did you quit?

How many cigarettes do you currently smoke (or did you previously smoke) **per day?**

EXAMPLE

If you started smoking at the age of 21, you would fill in the ovals like this:



10 20 30 40 50 60 70 80 90
1 2 3 4 5 6 7 8 9

How many cigars or pipes do you smoke per week? none ○ <1 ○ 1-2 ○ 3-5 ○ 6-9 ○ 10+ ○

How many cans of smokeless / chewing tobacco do you use per week? none ○ <1/2 ○ 1/2 ○ 1 ○ 2 ○ 3+ ○

Are you exposed to passive (second hand) **smoke?** yes ○ no ○

ALCOHOL USE

How often do you drink alcohol? Number of times: never ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7+ ○ Per: week ○ month ○ year ○

(If you marked "never", please skip ahead to Drug Use section)

What type(s) of alcohol do you drink? beer ○ wine ○ liquor ○

How many drinks do you have per occasion? 1-2 ○ 3-5 ○ 6-9 ○ 10+ ○

How often do you have more than five drinks per occasion? never ○ occasionally ○ rarely ○ frequently ○

DRUG USE

none ○ current ○ previous ○ prefer to discuss with physician ○

HABITS

Caffeine

Type(s) of caffeine: coffee ○ tea ○ soft drinks ○

Drinks per day: occasionally ○ none ○ 1-2 ○ 3-4 ○ 5-6 ○ 7+ ○

Exercise

Type(s) of exercise: bicycling ○ running ○ swimming ○ walking ○ aerobics ○ other ○

Times per week: occasionally ○ none ○ 1-2 ○ 3-4 ○ 5-6 ○ 7+ ○

How often do you wear a seatbelt? always ○ almost always ○ occasionally ○ never ○

Sun Exposure: occasionally ○ frequently ○ rarely ○

PAST MEDICAL HISTORY

Please indicate if YOU have a history of the following:

- ○ Anemia
- ○ Anesthetic Complication
- ○ Anxiety Disorder
- ○ Arthritis - Osteoarthritis
- ○ Arthritis - Rheumatoid
- ○ Asthma
- ○ Bladder Problems
- ○ Bleeding Disease
- ○ Blood Clots
- ○ Bowel Disease
- ○ Breast Cancer
- ○ Cervical Cancer
- ○ Colon Cancer
- ○ Chronic Bronchitis
- ○ Chronic Pulmonary/COPD
- ○ Claustrophobia
- ○ Dementia
- ○ Depression
- ○ Diabetes Mellitus
- ○ Emphysema
- ○ Heart Attack
- ○ Heart Disease
- ○ Heart Pain / Angina
- ○ Pacemaker
- ○ Hepatitis A
- ○ Hepatitis B
- ○ Hepatitis C
- ○ High Blood Pressure
- ○ High Cholesterol
- ○ HIV
- ○ Kidney Disease
- ○ Liver Cancer
- ○ Liver Disease
- ○ Lung Cancer
- ○ Mental Disabilities
- ○ Migraines
- ○ Multiple Sclerosis
- ○ Neuropathy
- ○ Osteoporosis
- ○ Physical Disabilities
- ○ Prostate Cancer
- ○ Rectal Cancer
- ○ Reflux/GERD
- ○ Seizures
- ○ Sexually Transmitted Disease (STD)
- ○ Skin Cancer
- ○ Stroke / CVA of the Brain
- ○ Stroke / Mini / TIA
- ○ Thyroid Problems
- ○ Other Disease, Cancer, or Significant Medical Illness (please specify):

  _____

  _____

  _____
- ○ **NONE of the Above**

ALLERGIES

Do you have any of these MEDICATION allergies?

- ○ Penicillin
- ○ Sulfa
- ○ Statins
- ○ Codeine
- ○ Aspirin
- ○ Vicodin/Norco
- ○ Metformin
- ○ Norvasc
- ○ Ace Inhibitors
- ○ Benadryl
- ○ Percocet
- ○ Morphine
- ○ Erythromycins
- ○ Hydrochlorothiazide
- ○ Phenol
- ○ Novocain
- ○ Bactrim
- ○ Antihistamines
- ○ Antidepressants
- ○ Cipro
- ○ Demerol
- ○ Lipitor
- ○ Tetanus
- ○ Naproxen
- ○ **NONE of the Above**

Do you have any of these FOOD allergies?

- ○ fish
- ○ eggs
- ○ nuts (tree)
- ○ seafood
- ○ pineapple
- ○ gluten
- ○ strawberries
- ○ peaches
- ○ soy
- ○ mushrooms
- ○ lactose
- ○ peanuts
- ○ cow's milk
- ○ **NONE of the Above**

Do you have any of these ENVIRONMENTAL allergies?

- ○ dust
- ○ animal dander
- ○ insect bites
- ○ insect stings
- ○ pollens
- ○ trees
- ○ grass
- ○ mites
- ○ mold
- ○ hay
- ○ **NONE of the Above**

Do you have any of these OTHER allergies?

- ○ tape
- ○ latex
- ○ soap
- ○ nickel
- ○ keflex
- ○ dyes
- ○ iodine
- ○ **NONE of the Above**

Do you have any allergies not listed above?

_____

_____

FAMILY MEDICAL HISTORY

Patient Name: _____

NO SIGNIFICANT FAMILY HISTORY Family History UNKNOWN

Mother, Grandmother, or Sister developed heart disease before the age of 65
Father, Grandfather, or Brother developed heart disease before the age of 55

Please indicate which family members have had these illnesses:	Father	Mother	Brother	Sister	Son	Daughter
Foot Problems						
Gout						
Liver Disease						
Arthritis						
Asthma						
Bladder Problems						
Bleeding Disease						
Breast Cancer						
Colon Cancer						
Depression						
Diabetes						
Heart Disease						
High Blood Pressure						
High Cholesterol						
Kidney Disease						
Lung / Respiratory Disease						
Migraines						
Osteoporosis						
Rectal Cancer						
Seizures / Convulsions						
Severe Allergy						
Stroke / CVA of the Brain						
Thyroid Problems						
Other Cancer						