Patient Information

Name _____ Phone (_____) _____ SS# _____

Address _____ City _____ State _____ Zip _____

Date of Birth _____ Male___ Female ___ Single___ Married ___ Widowed ___ Other ___

Email _____ Race/Ethnic Origin (Optional)_____

Employer _____ Employer's Phone (_____)_____

Employer's Address _____ City _____ State _____ Zip _____

Emergency Contact _____ Phone (_____)_____

Who may we thank for referring you? _____

Primary Insurance Information

Insurance Company _____ ID# _____Group# _____

Insured's Name _____ Patient's Relationship to Insured _____

Insured's Employer _____ Work Phone (_____)_____

Insured's Birth Date _____ Insured's SS# _____

Secondary Insurance Information

Insurance Company _____ ID# _____Group# _____

Authorization for Treatment & Acknowledgement of Receipt of "Notice of Privacy Practices"

I authorize the examination and treatment upon: (Patient Name) _____
be performed by any doctor affiliated with Ankle and Foot Centers of Missouri, P.C.

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 if I so chose) and understood the Notice.

Patient Signature/ Parent or Legal Guardian _____Date _____

Assignment of Benefits for Commercial/Medicare/Medicaid/Medigap Authorization

The undersigned authorizes the attending doctor to furnish and release to all insurance companies insuring the patient named above, the Social Security Administration and Health Care Financing Administration or its intermediaries any and all information with respect to any illness or injury for which the patient is receiving treatment and related claims. This shall include copies of medical records if requested. I permit a copy to be used in place of the original. I authorize payment of my medical benefits directly to the physician for services rendered. I understand I am financially responsible to Ankle & Foot Centers of Missouri, P.C. for any balances not covered by this authorization including deductibles, co-insurance, and co-pays. I understand that payment may be from federal and/or state funds. I further understand that I am responsible for payment should Medicare or Medicaid determine that the care I received is a non-covered service. I hereby authorize payments of my Medigap benefits to any/all doctors affiliated with Ankle and Foot Centers of Missouri, P.C. for all claims filed on my behalf. This authorization applies to all services until my representative or I revoke it.

Patient Signature/ Parent or Legal Guardian _____Date _____

Medical History
Surgeries you have had:

_____
_____
_____

Past Medical History:

_____
_____
_____

Hospitalization other than for the surgeries listed:

_____
_____
_____

Are you diabetic? _____ Yes _____ No Family History of Diabetes? _____

Have you recently or have you ever been to another podiatrist?_____ Date _____

Family Physician _____ Last Visit Date _____

Medications
Do you take oral contraceptives? _____ Yes _____ No
Include prescription, over the counter medications, and vitamins you are currently taking:

_____
_____
_____

Pharmacy Name(s) _____ Phone (_____)_____

Allergies

_____ Adhesive / Tape	_____ Demerol	_____ Penicillin
_____ Anticoagulant Therapy	_____ Iodine	_____ Seafood
_____ Aspirin	_____ Local Anesthetics	_____ Sulfa
_____ Codeine	_____ Novacain	_____ Other _____

Substance use:

Type	**Frequency**	**Amount**	**Past Use**
Tobacco			
Caffeine			
Alcohol			
Illegal drugs			

AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize Ankle and Foot Centers of Missouri, P.C. to use or disclose my Personal Health Information (PHI) as described below. I understand that, if the organization authorized to receive my PHI is not a health plan or healthcare provider, the released PHI may no longer be protected by federal privacy regulation. Our Notice of Privacy Practices provides detailed information about how we may use and disclose this PHI.

Patient authorizes communication with family/friend regarding your care and test results:

Name: _____Phone: _____ Relationship: _____

Name: _____Phone: _____ Relationship: _____

Patient authorizes communication with family/friend regarding your account billing:

Name: _____Phone: _____ Relationship: _____

Best way to contact you regarding messages, responses, appointment reminders, etc. (number 1-2. 1 being the best)

Home phone ____ _____ Cell phone ___ _____

May we leave a message on home voicemail? ☐Yes ☐No ☐N/A

May we leave a message with whomever answers the home phone? ☐Yes ☐No ☐N/A

May we leave a message on your cell phone voicemail? ☐Yes ☐No ☐N/A

You have the right to revoke this consent in writing, except to the extent we already have used or disclosed your PHI in reliance on your consent.

Signature of patient (or patient representative): _____

Printed Legal Name of patient (or patient representative): _____

Date: _____