Ankle and Foot Center of Charlotte

Medicare/Medicaid Patient's Certification: I certify the information given by me in applying for payment under Title XVIII and XIX of the Social Security Act is correct. I request payment be made directly to the provider of services on behalf and I authorize said provider to release any and all information necessary regarding treatment and services provided.

Assignment of Benefits: I hereby authorize payment directly to Ankle & Foot Center of Charlotte for any office visits, xrays, surgical and/or medical services. **Payment for Services:** I understand that I am financially responsible for all charges and fees related to the treatment and services rendered to me by Ankle & Foot Center of Charlotte, which are not covered by my medical insurance. I further understand that payment is expected at the time of each office visit to include co-payments, deductibles and any services not covered by my insurance. **Insurance:** If you are enrolled in one of the managed care/insurance plans with which we participate, we will file your insurance as a service to you. If our office does not hear from your insurance company within 30 days, we request your help in contacting your insurance company to resolve the payment delay. Your insurance plan is a contract between you and your insurance company, and we must hold you responsible for any balance(s) due.

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 email 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 Lendor/Creditor, its ancillary providers. HIPAA business associates, vendors, and its debt collection agents may contact me/us as described above.

Receipt of Notice of Privacy Practices: I attest that I have received a copy of the Ankle & Foot Center of Charlotte's Notice of Privacy Practices. I also request that the following information be followed in regards to my Personal Health Information (PHI). By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior consent. The practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA)

May we leave a detailed message on your voicemail?

Circle: YES OR NO

I grant Ankle and Foot Center of Charlotte permission to discuss my medical information with the

following person/persons (not including yourself): _____

_____

_____ _____

SIGNATURE OF RESPONSIBLE PARTY DATE

PATIENT RECORD TODAYS DATE_____

Patients Full Name:

Last:_____First:_____MI:_____ Sex: M F

Date of Birth: _____ Patient SS#:_____

Marital Status: S M D W Name of Spouse: _____

Race: _____ Ethnicity: _____ Language: _____

Phone:_____Work:_____Cell: _____

Billing Address:_____

City:_____ State:_____ Zip:_____

Email:_____

Physicians Name:_____ Date last seen:_____

Name and **relationship** of Emergency Contact: _____

Phone number of Emergency Contact: _____

_____ _____
SIGNATURE OF RESPONSIBLE PARTY DATE

Person responsible for services rendered if different than listed above

Name_____ SS#_____

Address_____

Phone_____ DOB _____

- Please describe what brings you to the office today?

  _____

  _____

- How would you describe your pain?

Sharp Aching Throbbing Shooting

Electrical Sensation Pins and Needles Burning

- Location of pain or primary complaint:

Lower Leg Ankle Achilles tendon Heel Midfoot Arch Forefoot

Sole of Foot Ball of Foot Top of Foot Big Toe Lesser Toes Toenails

- How long has your problems been present?

1 – 3 Days 3 – 7 Days 1 – 3 Weeks 3 – 6 Weeks 6 – 8 Weeks

3 – 6 Months 6 – 9 Months 9 – 12 Months Greater Than 1 Year

- Onset of condition or injury:

Gradual Onset Over Time Sudden Onset From Activity or Injury

- Course/progression of condition:

Severe Worsening Moderate Worsening Mild Worsening Steady / Unchanging

Mild Improvement Moderate Improvement Considerable/Good Improvement

- Pain / condition aggravated by:

Any Weight Bearing Standing Walking Running Exercise

Bending Stooping Pressure to Ball of Foot Pressure from Shoes Pressure from Jumping

- Have you attempted any treatments to relieve your problem?

Rest Ice Elevation Change Shoe Gear Over the Counter Padding

Over the Counter Anti-Inflammatory Medication (Motrin, Aleve, Tylenol, Aspirin, etc)

In-Home Whirlpool Stretching Trimming Out Toenail Yourself Applying Skin Cream

Applying Topical Antibiotic Ointment (Triple Antibiotic, Bacitracin, Neosporin, etc.)

- How much improvement and relief have you achieved with previous treatments?

Mild Improvement Moderate Improvement Considerable Improvement

No Improvement Worsening of Condition

- What is your activity level:

Sitting Standing Walking Considerable Movement/Walking Retired

- Name of Primary Care / Family Physician (First and Last name)?

_____

- Date last seen by Primary Care / Family Physician (Month, Day and Year if known)

_____

- How did you hear about our office?

Physician Family/Friend Internet Newspaper
Phone Book Advertisement Other _____

- Past medical history:

Hypertension/High Blood Pressure HIV/AIDS Hepatitis Heart Attack/MI Insulin Dependent Diabetes
Non-Insulin Dependent Diabetes Stroke/CVA Aneurysm Blood Clot

- Do you have:

Fatigue Nausea Chills
Weight Loss Greater Than 10 Pounds Weight Gain Greater Than 10 Pounds

- Eyes - Do you have:

Impaired Vision Cataracts Glaucoma
Macular Degeneration Frequent Eye Infections

- Ears - Do you have:

Hearing Loss Frequent Ear Infections
Dizziness Loss of Balance

- Nose - Do you have:

Sinus Problems/Allergies Frequent Nose Bleeds Difficulty Breathing

Nasal Polyps Deviated Septum

- Throat - Do you have:

Frequent Throat Infections Hoarseness
Difficulties with Speech Frequent Swollen Nodes/Glands in Neck

- Respiratory - Do you have:

Asthma Bronchitis Emphysema Shortness of Breath Tuberculosis
Valley Fever Lung Cancer Collapsed Lung/Atelectasis Pneumonia

- Cardiovascular - Do you have:

Hypertension/High Blood Pressure Myocardial Infarct/Heart Attack Chest Pain Angina
Palpitations/Irregular Beats Valve Prolapse/Heart Murmur Rheumatic Fever
Angioplasty Open Heart/Bypass Surgery Pacemaker Congestive Heart Failure

- Vascular/Circulation - Do you have?

Circulation Disorder/Decrease Leg Pain at Rest Leg Pain with Walking Atherosclerosis/Blocked Arteries
High Cholesterol Phlebitis Blood Clot/Deep Vein Thrombosis Varicose Veins

- Gastrointestinal - Do you have:

Reflux/Heart Burn Ulcer Abdominal Pain Gallbladder Problems Liver Disorder
Hepatitis A Hepatitis B Hepatitis C
Excessive Hunger Excessive Thirst Loss of Appetite Colitis

- Genitourinary - Do you have:

Frequent Bladder/Urinary Tract Infections Kidney Stone Frequent Urination/Incontinence
Renal Failure Renal Dialysis Ovarian Cancer (Female Only) Prostate Cancer (Male Only)

- Genitourinary - Have you had any of the following Sexually Transmitted Diseases?

Gonorrhea Syphilis Chlamydia Herpes HIV

- Hematological -Do you have:

Anemia Sickle Cell Disease or Trait Cancer/Leukemia Blood Transfusion

- Hematological – Are you anticoagulated with any of the following blood thinners?

Coumadin Heparin Aspirin Plavix

- Endocrine - Do you have:

Diabetes
Thyroid Disease

- Neurological - Do you have:

Seizures Stroke Tremor Change in Memory Frequent Headaches
Polio Muscle weakness Neuro-Muscular Disease Numbness Sciatica

- Musculoskeletal - Do you have:

Arthritis/Degenerative Joint Disease Rheumatoid Arthritis Gout Back Pain
Hip Pain Knee Pain Frequent Muscle/Tendon Pain

- Musculoskeletal - Do you have any of the following joint replacements/prosthesis:

Hip Knee Ankle
Hands Feet Spine

- Date of joint replacement:

_____

- Integument - Do you have:

Skin Rashes Psoriasis Eczema Skin Cancer Hives Skin Growth
Color Change to Mole or Wart Change in Size of Skin Growth Itching to Skin Thick Scar/Keloid

- Psychiatric - Do you have:

Depression Nervousness Anxious/OCD Phobias Bipolar Disease Memory Loss
Concentration Difficulties/ADHD Feelings of Worthlessness/Low Self Esteem Suicidal Schizophrenia/Psychosis

- Immunology - Do you have:

HIV Frequent Infections/Weak Immune System Chronic Fatigue Syndrome/Epstein- Barr

- Past Medical History – Injuries/Trauma

_____

- Have you had any of the following foot surgeries:

Toenail Bunion Hammertoe Fracture Repair Joint Fusions
Tendon Repair/Rerouting Ankle Stabilization Arthroscopy Fasciotomy

- Please list approximate month and year of any surgery listed above:

_____

- Past Surgical History: Have you had any of the following surgeries?

Heart Bypass Heart Valve Repair/Replacement Appendectomy
Gallbladder Brain Surgery Other

- Please list approximate month and year of any surgery listed above:

_____

- Any other surgeries? (Please specify type of surgery and date)

_____

- Any complications/problems with surgery or anesthetics? (please specify)

_____

- Previous hospitalization - have you been admitted for:

Heart Attack Stroke Pneumonia Cancer
Infection Injury Other Hospitalizations

- Please list approximate month and year of any hospitalization listed above:

_____

- Childhood History – Have you ever had:

Rheumatic Fever Measles Mumps Chickenpox Herpes/Cold Sores

- Childhood Immunizations – have you been immunized for:

Measles Mumps Rubella Diphtheria Tetanus
Varicella Zoster Polio Tuberculosis Pneumonia Flu

- Family History - Father - Does/Did your father have:

Hypertension/High Blood Pressure CVA/Stroke Diabetes
Cancer Circulation Problems

- Any other illnesses? (please list) _____

- Is your father deceased? Yes No

- If your father is deceased - age and cause of death_____

- Family History - Mother - Does/did your Mother have:

Hypertension/High Blood Pressure CVA/Stroke Cancer
Circulation Problems Diabetes

- Any other illnesses? (please list) _____

- Is your mother deceased? Yes No

- If your mother is deceased - age and cause of death_____

- Family History Siblings - Does/Did your siblings have:

Hypertension/High Blood Pressure CVA/Stroke Cancer
Circulation Problems Diabetes

- Do you have any other illnesses? (please list) _____

- Current Occupation: _____

- Marital status/ Living arrangement:

Married Single Widowed Divorced Other

- Social History - Do you currently:

Smoke Tobacco Smoke Marijuana Use Hallucinogenic Drugs
Drink Alcohol Vape Use Cocaine Use Other Recreational Drugs

- If you currently smoke, number of packs per day?

1/2 1 2 3 4 5 or more
1 -2/Week 3 – 4/Week Occasional social weekends

- If you used to smoke:
  - What year did you quit? _____
  - How many packs did you used to smoke per day? _____
  - How many years did you smoke? _____

- Number of drinks per day?

1 2 3 4 5 Greater Than 5 per Day
1 – 3/Week 4 – 6 /Week Occasional Use Only Social Drinking Only Weekend Drinking Only

- Women - Are you pregnant?

  YES NO

- If pregnant, number of months:

  _____

- Education:

Did Not Complete High School Complete High School Some College Completed College

Some Grad School Masters Degree Doctorate Degree

- Medications - please list medications (including aspirin) currently taking:

IF NO MEDICATIONS, PLEASE WRITE N/A

_____

_____

_____

- Allergies - Do you have allergies to any medications?

Penicillin Sulfa Erythromycin

Aspirin Cortisone Codeine Adhesive Tape

Local Anesthetics **No Known Allergies**

- Other medication allergies? - please list:

_____

- Do you have any food allergies? - if so, please list:

_____

- Do you have any allergies to plants? - if so, please list:

•What is your height? •What is your weight? •What is your shoe size?

_____ _____ _____