PATIENT HISTORY

LAST NAME FIRST NAME MIDDLE INITIAL SS# DATE

NAME: SPOUSE, PARENT OR GUARDIAN

BY WHAT NAME DO YOU WISH TO BE ADDRESSED? PATIENT'S EMPLOYER

DATE OF BIRTH AGE HOME PHONE NUMBER CELL PHONE NUMBER

ADDRESS CITY, STATE, ZIP

WHOM MAY WE THANK FOR REFERRING YOU TO OUR OFFICE? _____

EMERGENCY CONTACT _____ RELATIONSHIP: _____ PHONE: _____

MARITAL STATUS ( ) SINGLE ( ) MARRIED ( ) WIDOWED ( ) DIVORCED

PRIMARY INSURANCE: _____ INSURED NAME: _____ INSURED DOB: _____ RELATIONSHIP: _____

SECONDARY INSURANCE: _____ INSURED NAME: _____ INSURED DOB: _____ RELATIONSHIP: _____

ADDRESS OF INSURED IF DIFFERENT THAN THE PATIENT: _____

I HAVE GIVEN PERMISSION FOR A MESSAGE TO BE LEFT WITH:

FAMILY MEMBERS: __ YES __NO IF YES, LIST FAMILY MEMBERS: _____

ON ANSWERING MACHINE: __ YES __NO SIGNATURE: _____

EMAIL ADDRESS: _____

NOTICE OF PRIVACY PRACTICE: THIS IS TO ACKNOWLEDGE THAT ANKLE & FOOT SPECIALISTS OF MARION, INC NOTICE OF PRIVACY PRACTICES HAS BEEN MADE AVAILABLE TO ME ON THE DATE STATED BELOW:

IN ORDER FOR US TO SUBMIT A CLAIM FOR SERVICES COVERED UNDER YOUR POLICY, WE MUST HAVE YOUR AUTHORIZATION TO RELEASE MEDICAL INFORMATION TO YOUR INSURANCE CARRIER.

I AUTHORIZE DR. TIMOTHY J. BROWN / DR. MATTHEW J. BROWN/DR. ANDREW J. BROWN TO FURNISH MY INSURANCE COMPANY WITH ALL NECESSARY INFORMATION REGARDING MY PRESENT ILLNESS OR INJURY. I ALSO AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO DR. TIMOTHY J. BROWN/ DR. MATTHEW J. BROWN/ DR. ANDREW BROW FOR MEDICAL SUPPLIES OR SERVICES PROVIDED.

I GIVE PERMISSION TO DR. BROWN TO EXAMINE AND TREAT MY ANKLE AND/OR FOOT CONDITIONS. IF SURGERY IS TO BE PERFORMED, THIS FORM IS TO BE USED IN CONJUNCTION WITH A SURGERY CONSENT FORM.

_____

SIGNATURE OF PATIENT/PARENT/GUARDIAN

REV: 02/20

PODIATRIC HISTORY

PATIENT'S NAME: _____ DATE: _____

NAME OF FAMILY PHYSICIAN:_____CITY/STATE_____LAST VISIT:_____

FAMILY HISTORY: SIBLINGS: ALIVE YES NO , IF NO CAUSE OF DEATH AND AGE:_____

_____

MOTHER ALIVE: YES / NO, IF NO CAUSE OF DEATH AND AGE: _____

FATHER ALIVE: YES / NO, IF NO CAUSE OF DEATH AND AGE: _____

PAST SURGICAL HISTORY, DATE, SURGEONS, LOCATION OF SURGERY, PROCEDURE AND OUTCOME: _____

_____

_____

PAST ANESTHESIA HISTORY:

LOCAL: _____ DATE: _____ PROBLEMS?_____

GENERAL: _____DATE: _____PROBLEMS?_____

PAST MEDICAL HISTORY: (HIGH BLOOD PRESSURE, HIGH CHOLESTEROL, DIABETES, ETC)

_____

_____

_____

CURRENT MEDICATIONS: (STRENGTH & DOSAGE)

_____

_____

_____

HT: _____ WT: _____ SHOE SIZE: _____

DIABETES: DO YOU TEST GLUCOSE EVERYDAY? _____

RECREATIONAL DRUG USE: YES / NO

TOBACCO: DO YOU SMOKE OR USE SMOKELESS TOBACCO? ____ HOW MUCH? _____ HOW LONG?_____

DO YOU DRINK ALCOHOL? YES / NO HOW MUCH? _____ HOW OFTEN? _____

FEMALES, ARE YOU PREGNANT? YES / NO HYSTERECTOMY? _____ WHEN? _____

HAVE YOU HAD A FLU / PNEUMONIA SHOT THIS YEAR? YES / NO IF SO, WHEN_____

HAVE YOU HAD AN EYE EXAM THIS YEAR? YES / NO IF SO, WHEN_____

COVID VACCINE: Y / N BOOSTER: Y / N

CHIEF COMPLAINTS:_____

_____

_____

_____

NATURE OF PAIN: ( ) SHARP ( ) BURNING ( ) DULL ACHE ( ) SORE ( ) THROBBING ( ) BRUISED ( ) PINS & NEEDLES

LOCATION OF PAIN OR LESION: _____

DURATION: _____ ONSET: ( ) SUDDEN ( ) GRADUAL FREQUENCY: ( ) CONSTANT ( ) INTERMITTENT

TIMING: ( ) WEIGHT BEARING ( ) NON WEIGHT BEARING ( ) SHOE AGGRAVATE ( ) DURING WORK ___AM ___PM

AGGRAVATING / ALLEVIATING FATORS: _____

PREVIOUS TREATMENTS ATTEMPTED: _____

DATE OF INJURY: _____

EXPECTATIONS OF TODAYS VISIT: _____

UPDATED BY: _____ DATE: _____

PATIENT HISTORY

PATIENT NAME: _____ DATE: _____ MR#_____

SYSTEM REVIEW: DOCUMENT THE POSITIVE AND PERTINENT NEGATIVE RESPONSES

CONTITUTIONAL SYSTEMS
GOOD GENERAL HEALTH .....YES NO
RECENT WEIGHT CHANGE .....YES NO
FEVER .....YES NO
FATIGUE .....YES NO

EYES
EYE DISEASE .....YES NO
WEAR GLASSES/CONTACT LENSES .....YES NO
BLURRED OR DOUBLE VISION .....YES NO
GLAUCOMA .....YES NO

EARS/NOSE/MOUTH/THROAT
HEARING LOSS OR RINGING .....YES NO
EARACHES OR DRAINAGE .....YES NO
CHRONIC SINUS PROBLES OR RHINITIS .....YES NO
NOSE BLEEDS .....YES NO
MOUTH SORES .....YES NO
BLEEDING GUMS .....YES NO
BAD BREATH OR BAD TASTE .....YES NO
SORE THROAT OR VOICE CHANGES .....YES NO
SWOLLEN GLANDS IN NECK .....YES NO

CARDIOVASCULAR
HEART TROUBLE .....YES NO
CHEST PAIN OR ANGINA PECTORIS .....YES NO
PALPITATION .....YES NO
SHORTNESS OF BREATH WITH WALKING
LAYING FLAT .....YES NO
SWELLING OF FEET, ANKLES, HANDS .....YES NO
ATRIAL FIBRILLATION .....YES NO

RESPIRATORY
CHRONIC OR FREQUENT COUGHS .....YES NO
SPITTING UP BLOOD .....YES NO
SHORTNESS OF BREATH .....YES NO
ASTHMA OR WHEEZING .....YES NO

GASTROINTESTNAL
LOSS OF APPETITE .....YES NO
CHANGE IN BOWEL MOVEMENTS .....YES NO
NAUSEA OR VOMITING .....YES NO
FREQUENT DIARRHEA .....YES NO
PAINFUL BOWEL MOVEMENTS OR
CONSTIPATION .....YES NO
RECTAL BLEEDING / BLOOD IN STOOL .....YES NO
ABDOMINAL PAIN OR HEARTBURN .....YES NO
PEPTIC ULCER (STOMACH / DUODENAL).....YES NO

GENITOURINARY
FREQUENT URINATION .....YES NO
BURNING OR PAINFUL URINATION .....YES NO
BLOOD IN URINE .....YES NO

MUSCULOSKELETAL
JOINT PAIN .....YES NO
MUSCLE PAIN OR CRAMPS .....YES NO
BACK PAIN OR BACK INJURY .....YES NO
DIFFICULTY WALKING .....YES NO
JOINT STIFFNESS / SWELLING .....YES NO
WEAKNESS OF A MUSCLE OR JOINT .....YES NO
RHEUMATOID ARTHRITIS .....YES NO

INTEGUMENTARY (SKIN/BREAST)
RASH OR ITCHING .....YES NO
CHANGE IN SKIN COLOR .....YES NO
CHANGE IN HAIR OR NAILS .....YES NO
VARICOSE VEINS .....YES NO

NEUROLOGICAL
FREQUENT OR RECURRING HEADACHES.....YES NO
LIGHT HEADED OR DIZZY .....YES NO
CONVULSIONS OR SEIZURES .....YES NO
NUMBNESS / TINGLING SENSATION .....YES NO
TREMORS .....YES NO
PARALYSIS .....YES NO
STROKE .....YES NO
HEAD INJURY .....YES NO

PSYCHIATRIC
MEMORY LOSS OR CONFUSION .....YES NO
NERVOUSNESS .....YES NO
DEPRESSION .....YES NO
INSOMINIA .....YES NO
ANXIETY .....YES NO
PANIC ATTACKS .....YES NO

ENDOCRINE
GLANDULAR / HORMONE PROBLEMS .....YES NO
THYROID DISEASE .....YES NO
DIABETES INSULIN? / NON INSULIN? ..... YES NO
EXCESSIVE THIRST / URINATION .....YES NO
SKIN BECOMING DRYER .....YES NO

HEMATOLOGICAL / LYMPHATIC
SLOW TO HEAL AFTER CUTS .....YES NO
BLEEDING / BRUISING TENDENCY .....YES NO
ANEMIA .....YES NO
PHLEBITIS .....YES NO
PAST TRANSFUSION .....YES NO
ENLARGED GLANDS .....YES NO

ALLERGIC / IMMUNOLOGIC
HISTORY OF SKIN REACTION OR OTHER ADVERSE REACTION TO
PENICILLIN, SULFA, OTHER ANTIBIOTIC .....YES NO
REACTION?_____
MORPHINE, DEMEROL, OR OTHER NARCOTICS.....YES NO
REACTION?_____
NOVACAINE OR OTHER ANESTHETICS .....YES NO
REACTION?_____
ASPRIN OR OTHER PAIN REMEDIES .....YES NO
REACTION?_____
OTHER DRUG / MEDICATIONS .....YES NO
REACTION?_____
KNOWN FOOD ALLERGIES .....YES NO
REACTION?_____
LATEX ALLERGY .....YES NO

PHARMACY: _____

Ankle and Foot Specialists of Marion

Your insurance policy is a contract that exists between you and your insurance company. Our relationship is with you, the patient, and not the insurance company. If you have questions about your policy, please call the phone number provided on the back of your insurance card. The patient or responsibly party is responsible for their bill being paid in full. Upon your initial visit you will be asked to provide a photo ID. Please inform us at every visit of any changes to your insurance coverage and provide us with your most recent insurance card.

Please initial each line indicating your understanding of our policies:

____**COPAYMENTS:** It is a requirement of your insurance company that we collect your co-pay. Payment is required before meeting with the doctor.

____**DEDUCTIBLES & CO-INSURANCE:** If you have a high deductible plan, we may collect a **$125** deposit to apply towards your deductible and co-insurance. Any remaining balance after submission to your insurance company is your responsibility.

____**SELF-PAY (for non-covered products and services and for patients without insurance coverage):** Full payment is due at time of service. Payment for evaluation and management services at minimum will be required before seeing the doctor. Additional procedures/services may be recommended by the doctor. You will be informed of these charges before proceeding with treatment.

____**REFERRAL:** If your insurance plan requires a referral from your primary care doctor, this will be required at the time of your visit. Without a referral available, we will need to reschedule your appointment.

____**NO SHOW(failure to present for your appointment): 24 hours-notice** is required for cancellation of your appointment and failure to do so will incur a **$50** fee. Failure to provide **24 hours-notice** for a scheduled office procedure will incur a **$100** fee.

____**SURGERY CANCELLATION:** Failure to provide **5 business-days'** notice before surgery will incur a **$500** fee.

____**BALANCES/COLLECTION FEES:** If payment of an outstanding balance is not received within 30 days from the postmark date of a mailed statement or e-statement time stamp, a **$10** re-billing fee may be added to each additional statement. Our practice offers the ability to view statements and submit payments conveniently and securely online. Patients with balances more than 90 days overdue will be turned over to collections and a **$35** administrative fee will be applied.

____**FMLA/DISABILITY/MEDICAL RECORDS:** There is a **$40** charge for having the doctor complete these forms. Requested forms will be completed within five business days of diagnosis and care plan. There is a **$30** fee to obtain a copy of your medical records.

I have read and understand these financial policies.

Patient Name (print):_____

Patient/Responsible Party Signature:_____

Date: ____/____/____