CASE # 11- ____________ Updated 01/11

FOOT & ANKLE CLINICS OF AMERICA
WELCOME TO OUR OFFICE-2011
Patient Information (Please Print)

Name_________________________________Age______ Date of Birth_______________Sex_____ Ht /Wt____________

Shoe Size______Marital Status____ Patient's Soc Sec #_______________________Home Phone#_____________________

Home Address___________________________________Apt/Floor# ______City_________________St____ Zip________

E-mail:____________________________@_______________Cell Phone**#**_______________________________________

Patient's Employer Name_____________________________________Phone_____________________________________

Address____Occupation_____________________________

Patient's **Primary** Insurance Name & ID#_______________________________Grp #__________ Copay Amount $ _______

Patient's **Secondary** Insurance Name & ID#_____________________________Grp #__________ Copay Amount $ _______

Claim Address for Insurance:____

Name of Insurance Holder/Relationship:_________________________ SS#___________________DOB______________
(if other than patient) **(must be filled for insurance billing purposes)**

How did you hear about our Practice?____

If internet please specify which web site____

In Case of an Emergency, Please Contact:___________________________________Relationship:____________________

Home Phone # (must be different #)__________________________ Work Phone #_________________________________

Family Physician:/Address____

Last Date Seen____Phone___________________________________

Former Podiatrist:_______________________________________ Reason & Date seen______________________________

List any Medications You Are Taking____

List any Allergies to Medicine/Other____

Are you Diabetic?______ Have you had any operations or serious illnesses?______________________________________

If **YES** Please List:____

Do you have, or ever had, any of the following? (Check, if yes)

☐Anemia	☐ Arthritis	☐ Asthma	☐ Tumors	☐ Blood Clots	☐Epilepsy
☐Poor Circulation	☐ Sickel cell	☐ Gout	☐ Varicose Veins	☐ GI Problems	☐HIV
☐Strokes	☐Heart Disease	☐Hepatitis	☐ Kidney Disease	☐High Blood Pressure	☐MRSA

Reason for seeing the Doctor Today:
Chief Foot Complaint ____
WE MUST KNOW IF THIS IS WORK RELATED AND WHAT THE WORKER'S COMP CASE NUMBER IS.__________________________
Is this the result of an accident?______ If **yes,** describe **type /location /date**____

- I HEREBY GIVE MY PERMISSION TO THE PHYSICIAN OF FOOT & ANKLE CLINICS OF AMERICA TO ADMINISTER ANY NON-SURGICAL TREATMENT THAT MAY BE NECESSARY TO TREAT MY FOOT CONDITION. - I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES (WHETHER OR NOT COVERED BY THE INSURANCE COMPANY) I UNDERSTAND IT IS MY RESPONSIBILITY TO BE KNOWLEDGEABLE ABOUT MY INSURANCE PLAN AND IT'S COVERAGE - I UNDERSTAND THAT IF I RECEIVE A CHECK FROM MY INSURANCE COMPANY FOR SERVICES PROVIDED BY FOOT & ANKLE CLINICS OF AMERICA, I AM RESPONSIBLE FOR PAYING FOOT & ANKLE CLINICS OF AMERICA IMMEDIATELY. - **CO-PAYMENTS MUST BE PAID AT THE TIME OF SERVICE.**

Signature____ Date_________________________

AUTHORIZATION I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS MY INSURANCE CLAIM.
♦**We need copies of ALL INSURANCE CARDS and YOUR DRIVER'S LICENSE/STATE ID.**
I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO FOOT & ANKLE CLINICS OF AMERICA, LLC

MUST SIGN Signature____ Date_______________________

FACA STAFF that reviewed information ___________________