PATIENT INFORMATION

(Please Print)

Last Name: _____ First Name: _____
Address: _____ City: _____ Zip code: _____
Home #: _____Cell #_____SSN #_____
Date of Birth: _____ Age: _____ Sex: M☐ F☐
Marital Status: S☐ M☐ D☐ W☐ P☐
Referred By: _____Personal Physician: _____
Employer: _____ Occupation: _____Ph# _____
Employer Address: _____
Spouse's Name: _____Employer:_____Ph #_____

RESPONSIBLE PARTY

(If Different From Above)

Name: _____Relationship: _____
Address (if different):_____Ph # _____
Employer: _____Ph# _____

INSURANCE INFORMATION

Primary Insurance: _____Insurance ID#_____
Policy Holder's Name: _____ DOB: _____
Secondary Insurance: _____ Insurance ID# _____
Policy Holder's Name: _____ DOB: _____

EMERGENCY CONTACT

Name: _____ Relationship: _____
Address: _____Ph # _____
Employer: _____ Occupation: _____Ph# _____

AUTHORIZATIONS

I hereby assign, transfer and set over to Patterson Foot & Ankle Associates all of my rights, title and interest to my medical reimbursement benefits under my insurance policy/policies. I authorize the release of any medical information needed to determine these benefits. I understand that I am financially responsible for all charges whether or not they are covered by insurance. This authorization will remain valid until I revoke it by written notice.

Signature: _____Date: _____

MEDICAL INFORMATION

This information is important for our records and your health

Describe your foot problem: _____
_____

How long has it been bothering you? _____

Have you had any past problems with your feet or ankles? Y☐ N☐
If yes, please list problem: _____

Shoe size: _____Current Weight: _____ Current Height: _____

Are you allergic or sensitive to: Penicillin Sulfa Tape Beta dine/Iodine

Please list any other allergies to medications: _____

Have you had problems taking Aspirin or Ibuprofen (Advil, Motrin)? Y☐ N☐

Have you had any problem with local anesthetics (Novacaine, Lidocaine)? Y☐ N☐
If yes, please list problem: _____

What medications do you take regularly? _____
_____

GENERAL HEALTH INFORMATION

Do you have: DIABETES: Y☐ N☐ HIV/AIDS: Y☐ N☐ HEPATITIS: Y☐ N☐

Please list any serious illnesses: _____

Please list any previous surgeries: _____

Are you currently under a Physician's care? Y☐ N☐
If yes, for what condition? _____

Family Physician: _____Date of last visit: _____

May we contact him/her about your health? Y☐ N☐

Pharmacy: _____ Ph # _____

PATIENT HISTORY:

( ) Heart Disease	( ) Arthritis	( ) Lungs
( ) Asthma	( ) Hormones	( ) Bladder
( ) Skin Disorders	( ) Tuberculosis	( ) Liver
( ) Weight Loss	( ) Slow Healing	( ) Migraines
( ) HIV/AIDS	( ) Kidneys	( ) Cancer
( ) Stomach Ulcers	( ) Anemia	( ) Hepatitis A/B/C
( ) Gout	( ) High Cholesterol	( ) High Blood Pressure
( ) Freq. Infections	( ) Neurological	( ) Circulation

Do you have any artificial joints? Y ☐ N ☐ If yes, please list: _____

Have you ever tested positive for: HIV/AIDS: Y ☐ N ☐ Hepatitis A/B/C/: Y ☐ N ☐

Do you have a heart valve implant? Y ☐ N ☐

FAMILY HISTORY:

Mother: Living/Deceased Cause of death: _____
Father: Living/Deceased Cause of death: _____
Brother(s): Living/Deceased Cause of death: _____
Sister(s): Living/Decease Cause of death: _____

Is there a family history (blood relative) that has:

( ) HEART DISEASE	( ) SEIZURES
( ) DIABETES	( ) STROKE
( ) ARTHRITIS	( ) BUNIONS
( ) ASTHMA	( ) HAMMERTOES
( ) BLEEDING DISORDER	( ) FLAT FEET
( ) MIGRAINES	( ) CIRCULATION PROBLEMS IN FOOT/ANKLE
( ) NEUROLOGICAL DISORDER	

Tobacco use: Y ☐ N ☐ Packs per day: _____ Years of use: _____

Have you ever smoked in the past? Y ☐ N ☐ Years of use: ____ Date stopped: _____

Do you drink alcohol? Y ☐ N ☐ Amount per day: _____ Years of use: _____

Recreational drug use: Y ☐ N ☐ Type: _____ Years of use: _____

Employment: Sits at job ( ) Stands at job ( ) Stands and walks at job ( ) Retired ( )

Does your employer require any particular type of shoes? Boots ☐ Heels ☐ Other ☐

Signature_____Date_____

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form please ask to speak with our Office Manager, Elizabeth Ardoin, in person or by phone at (210) 614-9610.

Signature below is acknowledgement that you have received this notice of our privacy practices or afforded the opportunity to read this notice.

Print Name: _____Signature:_____

Date: _____

If there is a balance due, I will receive a statement and if I do not respond or send payment, my account will be forwarded to collections.

Initials: _____

If your account is forwarded to an outside collection agency there will be a 25% fee added to your balance which will be your responsibility and I acknowledge that I will be terminated as a patient.

Initials: _____

PATIENT INFORMATION FORM:

Welcome to our office. We appreciate the opportunity to work with you. The following information is provided for your benefit so we may better assist you.

Initials

_____ 1) **Payments:** All applicable fees, deductibles, co-insurance or co-pays must be paid at the time services are rendered. We accept Cash, Visa and MasterCard. There will be a $25.00 charge for returned checks.

_____ 2) **Insurance: No Exceptions!** It is the patient's responsibility to provide proof of medical insurance at the time of the visit. If it is not provided, you will be responsible for full payment.

_____ 3) **Appointment time:** We ask that our patients arrive on time. Patients arriving 15 minutes past their appointment time will need to reschedule depending on availability.

_____ 4) **Change of Information:** Please provide us with any changes regarding your insurance, phone numbers, name changes, etc., as soon as possible.

_____ 5) **Non-Compliance:** Patterson Foot & Ankle Associates reserves the right to discontinue care for non-compliance of any of these policies.

_____ 6) **Cancellation:** If you need to cancel your appointment, be sure to call within 48 hours of the appointment.

_____ 7) **After Hours Care:** The doctor can be reached by dialing our main office number. Leave a message with the answering service and the physician will return your call as soon as possible. If you have a medical emergency dial 911 or go to the nearest emergency room.

I agree to the above policies and agree to terms regarding payment and payment responsibilities.

Signature **Date**