Patient Information

Todays Date:_____

Patient Name:_____ Date of Birth:_____

Address:_____ SS#_____-_____-_____

City:_____ State:_____ Zip:_____ Gender: M F

Home Phone: _____ Cell Phone:_____

Email Address:_____

Student: (*circle one*) Full-time Part-time

Marital Status: (*circle one*) Married Single Widowed Divorced

Ethnicity: (*circle one*) White African American Hispanic
Asian Pacific Islander Other

Emergency Contact:_____ Phone:_____

Primary Insurance:_____

Policyholder Name:_____Policyholder Date of Birth: _____

Policy #_____ Group #_____

Relationship to insured: (circle one) Self Spouse Dependent Child

Secondary Insurance: _____ Policyholder Name:_____

Policy #_____

Primary Care Doctor:_____ Phone:_____

Last Date seen by Primary Doctor:_____

Name of Doctor who referred you:_____Phone:_____

How did you hear about JE Foot & Ankle Associates?_____

FOOT & ANKLE ASSOCIATES

Brief Medical, Family, and Social History

Height:_____ Weight_____ Shoe Size_____

Reason for visit:_____Duration of Problem:_____

If injury, please give date of injury:_____ Place of injury: Work, other_____

Have you had any serious illness or previous operations: YES NO If yes, please list below

_____

Do ***you*** have or have a history of any other following? Please indicate specific problem.

Eye Problems Asthma Rheumatic Fever Lung Disease

Heart Problems Numbness in foot/leg Diabetes Circulation Problems

Varicose Veins Swelling Kidney Disease Liver Disease Epilepsy

High Blood Pressure Arthritis Depression/Anxiety Cancer HIV/AIDS

Do you have any other condition or disease we should know about? *(Pregnancy, etc)*

_____

Allergies: *(Circle all that apply)*
None Penicillin Codeine Adhesive Tape Latex

Sulfa Iodine Aspirin Metals Local Anesthetic Other_____

Personal/Social History:
Use of:
Tobacco _____ If Yes, How often? _____
Alcohol _____ If Yes, How often? _____
Recreational Drugs _____ If Yes, What type & How often? _____

Family History: *(if any)*

_____

_____

_____

FOOT & ANKLE ASSOCIATES

Current Medications

Are you taking any medications at this time? YES NO If yes, please list below or attach

Medication	Dose	Medication	Dose

Preferred Pharmacy:_____Phone:_____

_____

Any other information you feel we should know about?

_____

_____

_____

Signature of Patient or Guardian:_____ Date:_____

FOOT & ANKLE ASSOCIATES

Financial Policy and Assignment of Benefits

This statement is to assist you in understanding our office policy for filing your insurance claims. Office visit co-pays and non-covered services and products must be paid for on the date of service. Our office accepts cash, check and credit card payments.
Returned checks will be charged a $20.00 service fee. We do offer a cash discount for those that have no insurance and payment must be made at the time services are rendered

Medical insurance is a contract between you and your insurance company and it is your responsibility to be knowledgeable of your insurance plan, i.e. referrals, co-pay, deductible and other benefits. Please be advised that not all services are covered by all plans, specifically orthotics and other medical supply items.

Medicare covers 80% after your deductible has been met, and will only pay for services that it determines to be "reasonable and necessary" under Section 1862 (a) (1) of the Social Security Act. If Medicare determines that a service or product is not covered, your supplemental insurance may or may not cover these services or products. If you do not have supplemental insurance, or your supplemental insurance does not cover the services or products **the remaining 20% is patient responsibility.**

I understand that I am financially responsible to the physician for charges not covered by my insurance. I understand that I may be charged interest at the rate of one and one half percent per month (18% per year) on any balance older than 90 days, or a rebilling fee of $5.00. If my account is referred to an outside collection agency, collection fees up to 40% of the total amount due and legal fees will be added.

I hereby give lifetime authorization for payment of insurance benefits to be made directly to JE Foot & Ankle Associates and any assisting physicians for services rendered. I hereby authorize this healthcare provider to release all information necessary to secure the payment of benefits.

There may be a $25.00 fee charged to your account if we do not receive a 24 hour notice prior to cancellation or change of an appointment. Reminder calls are a courtesy only.

Patient Name:_____

Signature of Patient or Guardian:_____Date:_____