ADVANCED FOOT CENTRE

WELCOME TO OUR OFFICE

PLEASE FILL OUT ALL INFORMATION COMPLETELY

DATE: _____

NAME: _____
LAST FIRST MIDDLE INITIAL

HOME ADDRESS: _____
STREET

_____
CITY STATE ZIP CODE

HOME PHONE#: _____ CELL. PHONE#: _____

PREFERRED PHONE# (please circle): HOME CELL. WORK

May we leave a message at your preferred phone #? YES NO

EMAIL ADDRESS: _____

DATE OF BIRTH: _____ AGE: _____

GENDER (please circle): Male Female

RACE (please circle): American Indian/Alaska Native Asian Black/African American
Hawaiian/Pacific Islander White Other

ETHNICITY (please circle): Hispanic or Latino Not Hispanic or Latino Unknown

MARITAL STATUS (please circle): Single Married Divorced Widowed

DRIVERS LICENSE #: _____ SOCIAL SECURITY #_____

EMPLOYER'S NAME: _____

WORK ADDRESS: _____

WORK PHONE#: _____ EXT.: ____ OCCUPATION: _____

SPOUSE'S NAME: _____

SPOUSE'S DATE OF BIRTH: _____ SPOUSE'S PHONE NUMBER: _____

EMERGENCY CONTACT: _____ RELATIONSHIP: _____

EMERGENCY CONTACT PHONE NUMBER: _____

WHOM MAY WE THANK FOR REFERRING YOU TO US? _____

PLEASE FILL OUT IF YOU ARE THE PATIENT'S PARENT OR GUARDIAN

YOUR NAME: _____

YOUR ADDRESS (if different from Patient): _____

_____

YOUR PHONE NUMBER: _____ YOUR RELATIONSHIP TO PATIENT: _____

YOUR DATE OF BIRTH: _____YOUR SOCIAL SECURITY#: _____

INSURANCE INFORMATION

**SUBSCRIBER'S NAME (if different from Patient): _____

**SUBSCRIBER'S DATE OF BIRTH: _____

**SUBSCRIBER'S RELATIONSHIP TO PATIENT_____

INSURANCE CARRIER: _____

IDENTIFICATION NUMBER: _____

GROUP/PLAN NAME/NUMBER: _____

CARRIER'S PHONE NUMBER (for providers): _____

SUBSCRIBER'S SOCIAL SECURITY #_____ SUBSCRIBER'S EMPLOYER: _____

MEDICAL HISTORY (Please fill out completely)

HEIGHT: _____ WEIGHT: _____ SHOE SIZE: _____

Family Physician: _____

Phone #: _____Last Visit: _____

Have you previously seen a Foot Specialist? Yes No

Date of last visit: _____

Reason for your visit today: _____

_____

Pharmacy Name: _____

Pharmacy Address: _____

Pharmacy Phone #: _____

Please list all drug allergies: _____

_____

Are you allergic to latex? Yes No

Please list all MEDICATIONS and DOSAGES: _____

_____

_____

_____

_____

Please list all Previous Surgeries (including dates): _____

_____

Are you a smoker? Yes No Former smoker? Yes No How long? _____ Year quit: _____

Do you consume alcohol weekly? Yes No How much? _____ Type?: _____

Caffeine intake? Yes No How much daily: _____

HAVE YOU EVER HAD THE FOLLOWING (please circle):

Y N Diabetes, TYPE 1 Y N Diabetes, TYPE 2

Y N High Blood Pressure Y N Stomach Ulcer Y N Kidney Problems Y N Tuberculosis

Y N Difficulty in Healing Y N Heart problems Y N Shortness of Breath Y N HIV

Y N Liver Problems Y N Rheumatic Fever Y N Epilepsy

FAMILY HISTORY (please circle):

Y N Cancer Y N High Blood Pressure Y N Diabetes Y N Coronary Artery Disease

OFFICE and FINANCIAL POLICIES:

Please read and initial

When you make an appointment with our physician, it is our policy to call your insurance carrier and get your eligibility and basic benefits. If your plan requires that you have a referral prior to seeing a specialist, please present this referral to the front desk before your visit with the physician. If you do not have your referral with you for this appointment, we will need to reschedule your visit unless you choose to be seen without using your insurance benefits and pay for your visit in full.

_____ Insurance is a contract between you and your insurance company. As a courtesy to you, we will gladly file your insurance claim on your behalf. We allow 45 days from the date a claim is filed for the insurance company to pay. If the insurance carrier does not pay within this time, you will be responsible for the entire balance.

_____ An "Insurance Waiver" may be required acknowledging understanding of your responsibility for paying for non-covered services. Some insurance companies arbitrarily refuse to cover certain services. Please be prepared to pay for these services in full, or make financial arrangements with our front desk.

_____ We require a 24-hour advanced notice if you must cancel your appointment. Our office assistant will call you 24 hours prior to your appointment to confirm the date and time of your appointment. A missed appointment may be subjected to a charge.

_____ I have read the above office financial policies and I understand these policies given to me by Advanced Foot Centre.

_____ I authorize payment of Medical Benefits be made on my behalf to Advanced Foot Centre for any services furnished to me. I authorize the release of any medical information held by Advanced Foot Centre to the healthcare financing administration and its agents to process my claim.

I HEREBY GIVE MY PERMISSION FOR TREATMENT.

Signature: _____ Date: _____

ACKNOWLEDGEMENT OF RECEIPT

OF

NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read if I so chose) and understood the Notice.

This notice has been posted on our website as well as on display at our facilities.

_____ _____

Patient Name (Please Print) Date

_____

Parent or Authorized Representative (if applicable)

_____

Signature