ADVANCED FOOT CENTRE

HELLO WELCOME TO OUR OFFICE

PLEASE FILL OUT ALL INFORMATION COMPLETELY

DATE:________________________

PERSONAL INFORMATION

NAME ____
LAST FIRST MIDDLE INITIAL

HOME ADDRESS____
CITY STATE ZIP

HOME PHONE__________________ CELL PHONE__________________ WORK PHONE__________________

E-MAIL ________________________________ May we leave a message Y N

DATE OF BIRTH ____________ AGE ________ GENDER MALE / FEMALE WEIGHT __________ HEIGHT __________

MARTIAL STATUS: Single Married Divorced SS# __________________ DRIVERS LICENSE #__________________

PATIENT'S SHOE SIZE: __________________

Employer Name: ______________________ Address: ______________________________

Work Phone #:______________________ Ext: __________ Occupation: ______________________

SPOUSE/PARENT/GUARDIAN: NAME: ______________________________ DATE OF BIRTH______________

SPOUSE/PARENT/GUARDIAN: EMPLOYER:__________________________ WORK PHONE# ______________

SPOUSE/PARENT/GUARDIAN: DATE OF BIRTH: __________ SS#__________________ OCCUPATION:______________

EMERGENCY CONTACT: ______________________ Relationship ______________ Phone #: ______________

WHOM MAY WE THANK FOR REFERRING YOU TO US? ______________________________

MEDICAL HISTORY (Please fill out completely)

Family Physician: ______________________ Phone #: ______________ Last Visit: ______________

Have you previously seen a Foot Specialist? YES NO Last Visit: ______________

Reason for your visit today? ____

Please List all Drug Allergies: ____

Please List all MEDICATION AND DOSAGES:______________________________________

Please List all Previous Surgeries including dates: ______________________________

Surgeries cont.: ____

SMOKER? YES NO FORMER SMOKER? YES NO HOW LONG? __________ YEAR QUIT? ________

CONSUME ALCOHOL WEEKLY? YES NO HOW MUCH? ______________ TYPE? ______________________

CAFFEINE INTAKE? YES NO HOW MUCH DAILY? ______________________

DRUGS? YES NO

FAMILY HISTORY (please circle)

Y N Cancer Y N High Blood Pressure

Y N Diabetes Y N Coronary Artery Disease

PHARMACY NAME: ______________________________

PHONE #: __________________ **ADDRESS:** ______________________________

HAVE YOU EVER HAD THE FOLLOWING (please circle)

Y N Liver Problems	**Y N Stomach Ulcer**	**Y N Kidney Problems**	**Y N Diabetes**
Y N Tuberculosis	**Y N Difficulty in Healing**	**Y N Heart Problems**	**Y N Epilepsy**
Y N High Blood Pressure	**Y N Shortness of Breath**	**Y N Rheumatic Fever**	**Y N HIV**

Office and Financial Polices:
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” maybe 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 advance 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

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Parent or Authorized Representative (if applicable)

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Signature