ALBANY FOOT CLINIC

PATIENT INFORMATION

Patient_____
Last Name First Name Middle Initial

Address_____
Street

_____
City State Zip Code

Indicate the preferred phone number contact:

☐ Home (_____)_____

☐ Cell (_____)_____

☐ Work (_____)_____

E-mail_____

RESPONSIBLE PARTY (for minors)

Name_____ DOB_____

Contact Number (____)_____

Relationship to insured_____

CONTACT PERSON / CAREGIVER (if different from above)

Name_____

Contact Number (____)_____

Relationship_____

EMERGENCY CONTACT not in the household

Name_____

Contact Number (____)_____

Relationship_____

BILLING ADDRESS (if different from above)

Name_____

Contact Number (____)_____

Relationship_____

PRIMARY CARE / REFERRAL

Primay Care Physician_____

Referral _____

DEMOGRAPHICS

Date of Birth_____ **Sex**: ☐ M ☐ F
MM/DD/YYYY

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Occupation_____

Employer_____

Work Status: ☐ Full-Time ☐ Part-Time ☐ Self Employed ☐ Unemployed ☐ Retired ☐ Student ☐ Disabled

INSURANCE

Primary Insurance Company_____

Policy Number_____

Policy Holder Name_____ DOB_____

Secondary Insurance Co_____

Policy Number_____

Policy Holder Name_____ DOB_____

WORK COMPENSATION / INJURY CLAIM

Insurance Carrier_____

Claim #_____ Date of Injury_____

Contact Name_____ Phone #_____

Type of Injury: ☐ Work ☐ Auto ☐ Other

Treatment for workers compensation, auto and other injuries will be billed through the injury carrier if a claim has been filed and accepted for benefits. If a claim has not been filed or is pending, all treatment will be billed through the patient's health insurance carrier and all copays and deductibles will be the responsibility of the policy holder at the time of service until the claim is accepted. Patients without insurance will be charged a cash fee for services. Any fees collected prior to an accepted claim will be refunded per the policy holder's outlined benefits and provider contracts.

Preferred Pharmacy

Pharmacy Name _____

Pharmacy Street & City _____

MEDICAL COMPLAINT

Briefly explain the nature of your visit:_____

_____

MEDICAL HISTORY

Have you ever had any of the following: *Circle "Yes" or "No"*

Diabetes	Yes	No	Heart Attack	Yes	No	Rheumatoid Arthritis	Yes	No
Hypothyroidism	Yes	No	Angina	Yes	No	Osteoarthritis	Yes	No
Endocrine Disorder	Yes	No	Congestive Heart	Yes	No	Lupus	Yes	No
Peripheral Neuropathy	Yes	No	Failure	Yes	No	Psoriatic Arthritis	Yes	No
Multiple Sclerosis	Yes	No	Heart Disease	Yes	No	Gout	Yes	No
Cerebral Palsy	Yes	No	Heart Murmur	Yes	No	Musculoskeletal	Yes	No
Complex Pain	Yes	No	Artificial Heart Valve	Yes	No	Disorder	Yes	No
Syndrome	Yes	No	Irregular Heart Beat	Yes	No	Artifiical Joint	Yes	No
Seizure Disorder	Yes	No	High Blood Pressure	Yes	No	Back Pain	Yes	No
Neurological Disorder	Yes	No	Blood Clots/ DVT	Yes	No	Fibromyalgia	Yes	No
Paralysis	Yes	No	Thromboplebitis	Yes	No	Bone Infection	Yes	No
Dropfoot	Yes	No	Stroke	Yes	No	COPD	Yes	No
Sciatica	Yes	No	High Cholesterol	Yes	No	Asthma	Yes	No
Hearing Loss	Yes	No	Bleeding Disorder	Yes	No	Pulmonary Embolism	Yes	No
Blindness	Yes	No	Slow Healing Sores	Yes	No	Shortness of Breath	Yes	No
Macular Degeneration	Yes	No	Hepatitis	Yes	No	Sleep Apnea	Yes	No
Retinopathy	Yes	No	Liver Disese	Yes	No	Skin Disorders	Yes	No
Depression	Yes	No	Kidney Disease	Yes	No	Psoriasis	Yes	No
Anxiety	Yes	No	Dialysis	Yes	No	Eczema	Yes	No
Cancer	Yes	No	Stomach Problems	Yes	No	Poor Circulation	Yes	No
AIDS/HIV	Yes	No	Gastric Reflux	Yes	No	Raynauld's Disease	Yes	No
Dementia	Yes	No	Bowel Problems	Yes	No	Claudication	Yes	No
Developmental Delay	Yes	No	Other_____			Other_____		

ALLERGIES

☐ **NO DRUG ALLERGIES**

- ☐ Penicillin
- ☐ Amoxicillin
- ☐ Cephalexin/Keflex
- ☐ Sulfa
- ☐ Clindamycin
- ☐ Local Anesthetic
- ☐ Internal Iodine
- ☐ External Iodine
- ☐ Vicodin
- ☐ Codeine
- ☐ Oxycodone
- ☐ Aspirin
- ☐ Ibuprofen
- ☐ Gabapentin
- ☐ Lyrica
- ☐ Adhesive Tape
- ☐ Latex

Other:_____

MEDICATIONS

	MEDICATION NAME	DOSE	TIMES A DAY
1.			
2.			
3.			
4.			
5.			
6.			

SURGERIES

Have you had any of the following surgical procedures:

- ☐ Appendectomy
- ☐ Gallbladder
- ☐ Stomach
- ☐ Bowel Resection
- ☐ Hernia
- ☐ Fracture Repair
- ☐ Vein Stripping
- ☐ Leg Arterial Bypass
- ☐ Soft Tissue Mass
- ☐ Cyst Removal
- ☐ Hysterectomy
- ☐ Tubal Ligation
- ☐ C-Section
- ☐ Vasectomy
- ☐ Prostate
- ☐ Joint Fusion
- ☐ Shoulder
- ☐ Hip Replacement
- ☐ Knee Replacement
- ☐ Carpal Tunnel
- ☐ Heart Stent
- ☐ Heart Valve
- ☐ Heart Bypass
- ☐ Kidney
- ☐ Breast
- ☐ Tonsillectomy
- ☐ Cataract
- ☐ Back
- ☐ Amputation
- ☐ Wound Debridement
- ☐ Bunion
- ☐ Hammertoe
- ☐ Plantar Fasciotomy
- ☐ Achilles Tendon
- ☐ Flat Foot
- ☐ Neuroma
- ☐ Bone Spur from Foot

Other_____

Other_____

Other_____

SOCIAL HISTORY

Height:_____ Weight:_____ Shoe size:_____

Tobacco use: ☐ Never Smoked ☐ Former Smoker

Current Smoker (choose the most accurate option):

☐ Current some days

☐ Current every day

Packs Per Day: ☐ 1/2 pack ☐ 1 pack ☐ 2 packs

HIPPA NOTICE OF PRIVACY PRACTICES

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

_____ _____

Patient Name (Please Print) Date

_____

Parent or Authorized Representative (if applicable)

_____

Signature

I give permission for my medical or account infromation to be shared with a family member/caregiver.
Yes_____ No_____ (place initials on "Yes" or "No")

FINANCIAL POLICY

I request that payments for medical services for me or a dependent be paid to Albany Foot Clinic. I authorize the release of any information to aid in determining my benefits or to help in processing any claims. I understand that I am financially responsible for those charges that are not covered by my insurance company whether that be co-pays, deductibles, or non covered charges. I understand that I am ultimately responsible to ensure all authorizations for treatment are obtained prior to any services rendered and if they are not I may be responsible for my entire bill. The Albany Foot Clinic will try to assist in determining insurance benefit for services but this does not superceed the responsibility of the policy holder knowing what their insurance coverages are with regards to office visits, procedures, orthotics and other durable medical equipment and imaging tests. All known co-pays are due at the time of service. If the co-pay amount is not known the co-pay will be billed. If a known co-pay is not paid at the time of service, the co-pay will be billed with a $5.00 billing charge added. Patient's without insurance are expected to pay in full at the time of each visit. Albany Foot Clinic reserves the right to charge a missed appointment fee of $25.00 for any appointment that is not cancelled or rescheduled before 24 hours. Repeated missed appointments may prevent further appointments from being scheduled. Payments in full are expected upon receipt of the initial statement unless arrangements have been obtained for a payment plan. Second and third statements are each assessed a $10.00 late fee charge. Accounts that are sent to a collection agency are assessed an additional $25.00 + 10% collection fee.

_____ _____

Signature of Patient, Parent or Guardian Date