Patient Information Form

Today's Date: ______/ ______/____________

Name:____ Date of Birth: ____/_____/_________

(First) (Mi) (Last)

Sex: ☐M ☐ F Marital Status: ☐Single ☐Married ☐Separated ☐Divorced ☐Widowed

Race:____________________ Primary Language Spoken: _______________ Social Security Number: ______-_____-_________

Home Address: ____ City/State: ________________________ Zip: ___________

Home Phone No: (__________) ___________-_________________ Cell Phone No: (__________) ___________-____________

Work Phone No: (__________) ___________-__________________ E-Mail: ____

Please indicate preferred method of communication: ☐ Phone ☐Mail ☐E-Mail

Emergency Contact: _____________________________Relationship: __________________ Phone: (_____) ______-_____________

Who is responsible for payment (if other than yourself): _____________________________ Relationship: ______________________

Do you have a legal guardian or healthcare power of attorney? ☐ Yes ☐ No

If Yes, Name: _______________________________ Relationship: _____________________ Phone: (_____) ______-_____________

How were you referred? ☐MAIL ☐YELLOW BOOK ☐DEX ☐INSURANCE ☐INTERNET ☐RELATIVE/FRIEND

☐PATIENT ☐CLINIC ☐PHYSICIAN NAME: _________________________ ☐OTHER__________________________

Insurance Information

Insurance Company: ___________________________________ I.D No: _______________________ Group No:_________________

Primary Care Information

Primary Care Physician: ____

Clinic name: ____ Location: ______________________________

Pharmacy: ____ Location: ______________________________

Patient Name: ______________________________ DOB: ______________

What specific problem brings you to our office today? ______________________________

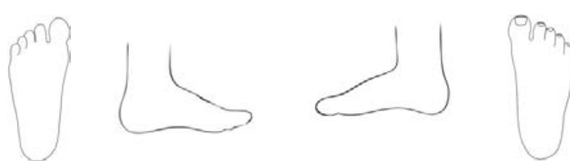
Where is the pain/problem located? Please mark on the diagram below.

Left foot

Top of foot **Inside of foot** **Outside of foot** **bottom of foot**

Right foot

bottom of foot **outside of foot** **Inside of foot** **Top of foot**



How long ago did this problem start? ____________ Work injury? ☐Yes (describe)______________ ☐No

How would you rate your pain on a scale from 0 (no pain) to 10(worst pain possible)? _____

Medical History

ALLERGIES:

☐No known allergies

☐I have the following allergies: ______________________________

Have you been vaccinated for influenza this year? ☐Yes ☐No

Have you ever had any of the following? Check all that apply

☐Abnormal Bleeding
☐Acid Reflux
☐Anemia
☐Arthritis
☐Asthma
☐Back Trouble
☐Bladder Infections
☐Blood Clots
☐Blood Transfusions
☐Bronchitis/Emphysema

☐Cancer
☐Diabetes
☐Fibromyalgia
☐Glaucoma
☐Gout
☐Heart Attack
☐Heart Disease/ Failure
☐Hepatitis
☐High Blood Pressure
☐Immunosuppressed

☐Kidney Disease
☐Liver Disease
☐Low Blood Pressure
☐Migraine Headaches
☐Mitral Valve Prolapse
☐Nerve Disorder
☐Neuropathy
☐Osteoporosis
☐Other:______________

☐Pneumonia
☐Polio
☐Rheumatic Fever
☐Skin Disorder
☐Sleep Apnea
☐Stomach Ulcers
☐Stroke
☐Thyroid Disease
☐Tuberculosis

PLEASE LIST ALL SURGERIES: ______________________________

CURRENT MEDICATIONS: (*If you have a list of medications, please present it to front desk for copying)*

Name	Dose	Name	Dose

Social History

Use of Alcohol: ☐Never ☐Rare ☐Occasional ☐Moderate ☐Daily ☐History of alcohol abuse

Use of Tobacco: ☐Never ☐Quit – how long ago? __________ ☐Smoke _____ packs/day for _____ years

Exercise: ☐Never ☐Rare ☐Occasional ☐Weekly ☐Several times a week ☐Daily

Family History

☐Diabetes ☐Cancer ☐Heart Disease ☐High Blood Pressure ☐Coronary Artery Disease

☐Stroke ☐Rheumatoid Arthritis ☐Thyroid Disease ☐Other ______________________________

PATIENT FINANCIAL POLICY

Your understanding our financial policies is an essential element of your care and treatment. If you have any questions, please discuss them with our office staff.

As a patient of Pinnacle Foot and Ankle Clinics, you are responsible for all authorizations/referrals needed to seek treatment in this office.

Unless other arrangements have been made in advance by you, or your health insurance carrier, payment for services at Pinnacle Foot and Ankle Clinics, is due at the time of service. We accept Visa, MasterCard, Discover, cash or check.

Your health insurance policy(s) is a contract between you and your insurance company(s). As a courtesy, we will file your insurance claim for you if you assign the benefits to the doctor. In other words, you agree to have your insurance company pay the doctor directly. If your insurance company does not pay the practice within a reasonable period, we will have to look to you for payment.

We have made prior arrangements with certain insurers and other health plans to accept an assignment of benefits. We will bill those plans with which we have an agreement and will only require you to pay the co-pay/co-insurance/deductible at the time of the service.

If you have insurance coverage with a plan we do not have a prior agreement, we will prepare and send the claim for you on an unassigned basis. This means the claim may be denied if out-of-network. Therefore, you are responsible for all charges of your care and treatment.

All health plans are not the same and do not cover the same services. In the event your health plan determines a service to be "ineligible for coverage" or you do not have an authorization, you will be responsible for the complete charge. We will attempt to verify benefits for some specialized services or referrals; however, you remain responsible for charges to any service rendered. Patients are encouraged to contact their plans for clarifications of benefits prior to services rendered.

You must inform Pinnacle Foot and Ankle Clinics of all insurance changes and authorization/referral requirements. In the event Pinnacle Foot and Ankle Clinics are not informed, you will be responsible for any charges denied.

Past due accounts are subject to collection proceedings. All costs incurred including, but not limited to, collection fees, attorney fees and court fees shall be your responsibility in addition to the balance due this office.

There is a service fee of $25.00 for all returned checks. Your insurance company does not cover this fee.

To the best of my knowledge, I have answered the questions on this form accurately. I understand that providing incorrect information can be dangerous to my health. I understand that it is my responsibility to inform the doctor and office staff of any changes in my medical status.

Print Name of Patient or Parent/Legal Guardian

If other than patient, relationship to patient

Signature **Date**

Privacy Practices Acknowledgement

I acknowledge that I have read and understood the
Notice of Privacy Practices.
I also understand that a copy will be provided to me if I so request.

Print Name of Patient or Parent/Legal Guardian

Signature **Date**