

Queen City Foot & Ankle Specialists

PERSONAL INFORMATION

Patient Name: First _____ Middle _____ Last _____

Sex: Male Female SSN (Last 4 only) _____ Date of Birth ____/____/____ Age: _____

Address: _____

City _____ State _____ Zip: _____ Email _____

Home Phone # _____ Cell Phone # _____ Work Phone # _____

Marital Status: Married/ Single/Divorced/Widow Name of Spouse (if married) _____ Phone # _____

Employer: _____ Occupation: _____

Emergency Contact: Name: _____ Phone: _____

Name: _____ Phone: _____

Pharmacy Name: _____ Phone # _____

Family Physician: _____ Phone #: _____

Referring Physician _____ Phone#: _____

Physician(s) Currently treating you: _____ Phone# _____

May we contact your physician(s) about your health? Yes No

Are you under treatment at this time? Yes No

Date of Last Visit: ____/____/____

Are you pregnant or Breastfeeding? Yes No

How did you learn of our office? (Please provide names)

____ Friend _____ Doctor _____

____ Yellow Pages ____ Newspaper ____ Other: _____

Describe in detail the problem you are having with your feet, the duration, and what makes it worse:

I acknowledge that I was provided and opportunity to read the **NOTICE OF PRIVACY PRACTICES** located on the clipboard and I understand the Notice.

Signature: _____ Date: _____

(PLEASE SEE PAGE 2)

Medical Information

This is important for our records and your health

Please List any Medical Allergies or Sensitivities and the Reaction below:

Medications? Y N List: _____
Tape or Adhesives? Y N List: _____
Aspirin or Ibuprofen (Advil, Motrin, Aleve)? Y N List: _____

Family History

Mother: Living Deceased Cause of Death: _____
Father: Living Deceased Cause of Death: _____
Brother(s): Living Deceased Cause of Death: _____
Sister(s): Living Deceased Cause of Death: _____

Is there a family (blood relative) History of:

Arthritis Heart Disease Diabetes Stroke Nerve problems Mental disease
 Circulation problems Bunions Flatfeet Hammertoes Sickle Cell Anemia
Other: _____

Please List all the drugs and herbal supplements that you currently take.

Current Height _____ Current Weight _____ Shoe Size _____

Do you have Diabetes? Y N If yes, Number of years _____
Controlled with: Insulin? _____ Pills? _____ Diet? _____

Have you ever been treated for any of the following? Please check below.

Stroke Heart Problems Circulation problems Mental Disease/Depression
 Arthritis Liver Problems High Blood pressure High Cholesterol
 Anemia Thyroid Disease Kidney/Bladder Disease Seizures
 Gout Asthma Back pain or injury HIV (+)
 Cancer (Type?) _____ Acid Reflux Bleeding tendencies Blood Clots
 Hepatitis Sickle Cell Stomach Ulcers
Other: _____

Have you had any previous surgery? Yes No

If yes, please list the surgeries and the approximate date: _____ Date _____
_____ Date _____
_____ Date _____

Do you drink alcohol or beer? Yes No
 Light usage, 1-2/week Moderate, 1-2/day Heavy, more than 2 daily

Do you smoke? Yes No Number of packs/day? _____

Previously smoked? Yes No Number of years _____

Do you use Street drugs or other substances? Yes No

Please List _____

I certify that the above is true and correct to the best of my knowledge.

Signed: _____ Date _____

***Queen City Foot and Ankle Specialists
Financial Policy***

- If the office does not participate with or accept assignment from your health insurance, payment in full will be due at the time of service unless prior arrangements have been made.
- Office visit co-payments are due at the time of service. If you do not have your copay in the form of cash, Visa or MasterCard you will be asked to reschedule your appointment.
- If you are a "Self-Pay" or uninsured patient payment for all services must be made at the time of service. NO EXCEPTIONS WILL BE MADE. Please ask for a CareCredit® application if you do not have funds available for your services.
- We are happy to file a claim on your behalf to your Health Insurance Company; however, once the insurance company is billed, we allow 60 days for the balance to be paid by your insurance company. If they do not remit payment within 60 days, the balance will be due in full from you.
- Claim denials due to no referral of authorization are the responsibility of the patient. Our office staff will assist you in referral/ pre-certification procedures, but final responsibility lies with the patient.
- We encourage our patients to be familiar with their insurance plan. If your plan states your services are not covered you will be responsible for payment.
- Please present your insurance card each visit, you will be responsible for payment in full if your insurance states that your coverage is no longer active or another insurance is primary.
- All unpaid balances are subject to a 2% interest or minimum \$5.00 service charge after 90 days.
- Please be on time for your appointment. We respect your schedule, and expect the same in return. If you need to reschedule your appointment, we require a minimum of 24 hours notice. If you miss a scheduled appointment without notifying our office a \$25.00 charge will be added to your account.
- Due to State and Federal Law we must pursue all unpaid balances to the fullest extent. Any balance that is not paid after 90 days will be sent to collections.
- If your account must be forwarded to a collection service and or attorney because of non-payment, you will be responsible for all collection fees charged by these services.

By my signature I acknowledge receipt of this policy and hereby agree to its terms.

Printed Patient Name: _____ Date: _____

Signature: _____

If Patient is a minor or unable to sign please complete below:

Authorized Representative: _____ Relation: _____

Signature: _____

Insurance Company Name: _____

Member number: _____ Group: _____

Name of Insured Member: _____ DOB _____