Welcome to
Advanced Foot & Ankle Centers

PATIENT INFORMATION

Name _____ Date of Birth _____ Age _____
LAST FIRST MI

Address _____ City _____ State _____ Zip _____

SS # _____-_____-_____ Spouse, Parent or Guardian's Name _____

Home Phone (_____)_____-_____ Cell Phone (_____)_____-_____ Work Phone (_____)_____-_____

Employer _____ Employer Phone (_____)_____-_____

Please Check the Appropriate Boxes: ☐ Single ☐ Married ☐ Widowed ☐ Other ☐ Male ☐ Female

Preferred Language _____ Race _____ Hispanic _____Yes _____No

Emergency Contact _____ Emergency Contact Phone (_____)_____-_____

Referred to Office by: ☐ Dr. _____ ☐ Friend/Family _____ ☐ Phone Book

☐ Television Ad ☐ Internet Search ☐ Other _____ Email _____

INSURANCE INFORMATION

Primary Insurance _____ Policy # _____ Group # _____

Insured Name _____ Insured Date of Birth _____

Insured Employer _____ Insured Employer Phone (_____)_____-_____

Insured Employer Address _____ City _____ State ____ Zip _____

Patient's Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Secondary Insurance _____ Policy # _____ Group # _____

Insured Name _____ Insured Date of Birth _____

Insured Employer _____ Insured Employer Phone (_____)_____-_____

Insured Employer Address _____ City _____ State ____ Zip _____

Patient's Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

AUTHORIZATION FOR ASSIGNMENT OF BENEFITS

I hereby authorize payment of insurance benefits otherwise payable to me directly to the doctor. I agree to pay any balance not covered by the approved medical insurance. If for any reason the account should become delinquent, I agree to pay any interest charges, collection costs, and reasonable legal fees.

Signature _____ **Date** _____

Medical History

Reason for office visit:			
Duration of problem:			
Your height:		Your weight:	
ALLERGIES (LIST ALL KNOWN ALLERGIES OR REACTIONS TO DRUGS/MEDICATIONS)			
Penicillin	Sulfa	Local Anesthetic	Iodine
Codeine	Latex/Tape	Aspirin	Other Antibiotics

MEDICATIONS (PLEASE LIST ALL CURRENT MEDICATIONS YOU ARE TAKING – INCLUDING PRESCRIPTION AND NON-PRESCRIPTION/OVER THE COUNTER)			
MEDICATION	DOSE	MEDICATION	DOSE
What is your preferred pharmacy?			
SURGERIES (PLEASE LIST ALL SURGERIES YOU HAVE HAD)			

WHAT PREVIOUS TREATMENT HAVE YOU HAD ON YOUR FOOT/ANKLE? (PLEASE CIRCLE ALL THAT APPLY)			
Surgery	Orthotics	Cortisone Shots	Other

HAVE YOU HAD OR DO YOU CURRENTLY HAVE ANY OF THE FOLLOWING? (PLEASE CIRCLE THE CORRECT RESPONSE AND EXAMPLE IF APPLICABLE)					
Anemia	Yes	No	Kidney Problems	Yes	No
Arthritis/Rheumatism	Yes	No	Liver Disease or Problems	Yes	No
Artificial Joints (Hip, Knee, etc)	Yes	No	Lung Problems	Yes	No
Bleeding Problems	Yes	No	Neurological Disorder	Yes	No
Cancer	Yes	No	Phlebitis	Yes	No
Circulation Problems	Yes	No	Seizures	Yes	No
Diabetes (Type 1/Type 2)	Yes	No	Stomach Problems (Reflux, Heartburn, etc.)	Yes	No
Fainting Problems	Yes	No	Stroke	Yes	No
Gout	Yes	No	TB	Yes	No
Heart Problems (Attack, Murmur, Disease, etc.)	Yes	No	Thyroid	Yes	No
Hepatitis (A, B, or C)	Yes	No	Transfusions	Yes	No
High Blood Pressure	Yes	No	Ulcers	Yes	No

PLEASE ANSWER EACH OF THE FOLLOWING				
Do you smoke or use tobacco?	No	Yes	Previously, but quit	If yes, packs or amount per day:
Do you drink alcohol?	No	Yes	If yes, how often? Daily Occasionally Rarely	
Do you use drugs?	No	Yes	If yes, type of drug and frequency:	
If you are a woman, are you pregnant?			Yes	No
Prior hospitalizations?	If yes, please explain:			
Prior diagnosis of MRSA?	If yes, please explain:			
Family Medical History:				

FAMILY PHYSICIAN

Name of Primary Physician: _____
Physician's Address: _____ City _____ State _____ Zip _____
Physician's Phone Number (_____)_____-_____ Date of Last Visit with Physician _____

ADVANCED FOOT AND ANKLE CENTERS

Arthur R. Jeynes, DPM
Kristopher W. Krannitz, DPM
John A. Rialson, DPM

IMPORTANT OFFICE INFORMATION

Welcome to Advanced Foot and Ankle Centers. We are committed to providing you with the best care possible. Your understating of our Office Policy is very important to us. Please read the following information, sign and return it to us. We will be happy to discuss any questions that you may have.

INSURANCE AND CLAIM SUBMISSION: **We participate with many various insurance companies. As a courtesy, we will bill most insurance companies for our patients. Please understand that your insurance coverage is an agreement between you and your insurance company. Knowing your insurance benefits is your responsibility.**

PROOF OF INSURANCE: **All patients are required to compete and/or update our patient information form. You will be asked to verify your address, phone and insurance information. If you cannot provide up-to-date health insurance information, you will be responsible for payment in full.**

CO-PAYS AND DEDUCTIBLES: Co-pays and deductibles are the out of pocket expenses you are responsible for. Co-pays are required for all office visits, including follow-up examinations. Deductibles are determined by your policy with your insurance carrier. We collect office visit co-pays on the day of your visit. We can't write off co-pays and deductibles because we have signed a contract with the insurance carrier that stipulates we collect co-pays and deductibles from the patient.

YOUR ACCOUNT: Statements are billed monthly. Payment Plans are available based on balance and account history. Accounts that are 90 days past due with no payment history will be turned over to a collection agency. Personal checks that are returned for non-sufficient funds are subject to a $25.00 administrative fee.

MISSED APPOINTMENTS: **There will be a $25.00 fee charged to your account if you do not give 24 hours advance notice. If you are more that 15 minutes late, without notification, your appointment will be changed to a no show and you will be rescheduled. After 3 no show appointments you will be discharged from the practice.**

FORMS: There is charge for the physician to fill out forms. Two pages or less is $10.00. Three pages or more is $25.00. This is due at the time the form is picked up.

I have read and understand the office policy and agree to abide by its guidelines.

_____	_____	_____
Responsible Party Signature	**Relationship**	**Date**

Revised 05/08/2019

SUMMARY OF NOTICE OF PRIVACY PRACTICES

The Notice of Privacy Practices contains a detailed description of how our office will protect your health information, your rights as a patient, and our common practices in dealing with patient health information. The following material is a summary of that notice and is provided to asset you in understanding it's contents. Please note that a complete copy is available at the reception deck.

Uses and Disclosures of Health Information.
We will use and disclose your health information in order to treat you or to assist other health care providers in treating you. We will also use and disclose our health information in order to obtain payment for our services or to allow insurance companies to process insurance claims for services rendered to your by us or other health care providers. Finally, we may disclose your health information for certain limited operation activities such as quality assessment, licensing, accreditation, and training of students.

Uses and Disclosures Based on Your Authorization.
With the exception of the following circumstances, we may not use or disclose your health information without your written authorization:

- For purposes of public health and safety
- For certain limited research purposes
- For government authorities to prevent child abuse or domestic violence
- For government agencies for purposes of their audits, investigations, and other oversight activities
- For law enforcement authorities to protect public safety or to assist in apprehending criminal offenders
- For the FDA to report product defects or incidents
- When required by court orders, search warrants, subpoenas, and as otherwise required by law

Patient Rights.
As a patient, you have the following rights:

- To have access to your health information
- To request restrictions as to how your health information is used or disclosed
- To receive notice of our privacy practices

Acknowledgement of Notice of Privacy Practices
I acknowledge that I have received Advanced Foot and Ankle Centers' Notice of Privacy Practices. I have had full opportunity to read and considered the contents of the Notice of Privacy Practices.

Patient Name:_____ Relationship to Patient: _____

Signature:_____ Date:_____

PRESCRIPTION HISTORY CONSENT
I agree Advanced Foot and Ankle Centers may request and use my prescription medication history from other healthcare providers or third party pharmacy benefit payors for treatment purposes.

Signature: _____ Date:_____

Parent/Guardian Signature (If patient is a minor) _____

PLEASE READ AND SIGN THIS RELEASE OF INFORMATION SECTION
I, _____authorize Advanced Foot & Ankle Centers to release and/or discuss information relevant to my care to the following individuals:

Name and relationship_____

Name and relationship_____

Office Use Only
I attempted to obtain the patient's signature in acknowledgement of the Notice of Privacy Practices, but was unable to do so.
Date:_____ Initials:_____ Reason:_____