FOOT & ANKLE CENTER, INC - PATIENT INFORMATION SHEET

Patient (First)_____(Last))_____(Mid.Int)_____
Address Line 1_____
Address Line 2_____
City_____State_____ZipCode_____
Home (____)_____-_____ Work (_____)_____-_____
Mobile (____)____-_____
Email address_____
Emergency contact: Name_____Relationship_____
Phone (____)_____-_____

Sex □M □F Height___'___" Weight_____ Age_____ Date of Birth____/___/_____
Marital Status □Single □Married □ Widowed □ Separated □ Divorced
SocialSecurity#_____
Occupation_____ Employer_____
Referred by:_____
Family Physician_____ Phone (____)_____-_____
Date Last Seen by Family Physician_____
Primary Language_____ Race_____ Ethnic origin_____

Primary Insurance Company_____
Insurance ID# _____ Co-pay $_____
Subscriber Name _____ Relationship to patient _____
Subscriber Birth Date_____
Second Insurance Company _____
Insurance ID#_____

ASSIGNMENT AND RELEASE

I, the undersigned, certify that I (or my dependent) have insurance coverage with _____ and assign directly to The Foot and Ankle Center, Inc all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

RESPONSIBLE PARTY SIGNATURE_____
Relationship_____ Date ____/_____/_____

MEDICARE AUTHORIZATION

I request that payment of authorized Medicare benefits be made to me or on my behalf to The Foot and Ankle Center, Inc for any services furnished me by the physicians in that group. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits. I understand that my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated on item 9 of the HCFA-1500 form or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned claims, the supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for deductible, coinsurance and non-covered services.

BENEFICIARY SIGNATURE_____ Date____/_____/_____

Please complete next page

Please circle any condition that you have had in the following list:

Aids/HIV	Ear Problems	Psychiatric Care
Allergies to Anesthetics	Epilepsy	Radiation Treatment
Allergies to Medicine/Drugs	Eye Problems	Rash
Anemia	Fainting	Respiratory Disease
Angina	Foot or Leg Cramps	Rheumatic Fever
Arthritis	Gout	Shortness of Breath
Artificial Heart Valves/Joints	Headaches	Seizures
Asthma	Heart Disease	Sinus Problems
Back Problems	Hemophilia	Stroke
Bleeding Disorder	High Blood Pressure	Swelling in Ankles or Feet
Cancer	High Cholesterol	Swollen Neck Glands
Chest Pain	Kidney Problems	Tired Feet
Chronic Diarrhea	Liver Disease	Tuberculosis
Circulatory Problems	Low Blood Pressure	Ulcers
Diabetes	Phlebitis	Varicose Veins
Insulin or Non-Inslllin	Pregnant	Venereal Disease
		Weight Loss, Unexplained

Surgeries and/0r hospitalizations you have had

I_____

_____

Medications:

Include prescriptions, over-the-counter medications and vitamins _____ _____

_____ _____

_____

Pharmacy_____

Pharmacy Phone # ( ) _____-_____

Allergies: (circle ones that apply)

Adhesive/Tape	Local Anesthetics
Anticoagulant Therapy	Novocaine
Aspirin	Penicillin
Demerol	Sulfa
Codeine	Seafood
Iodine	Other_____

What is the chief complaint for which you came to be treated?

_____

_____

_____

Have you ever been to a Podiatrist before? _____

If yes, please list

Name ----------~------

Date of Last Visit ___/___/____

Is there any personal or family history of diabetes? _____

Cigarette *I* Tobacco Use? _____

Years Smoked _____

Please circle which foot problems you now have or have had in the past.:

Ankle Pain
Athlete's Foot
Bunions
Corns & Calluses
Cramps/Numbness in feet/legs
Flat Feet
Foot or Leg Cramp
Heel Pain
Ingrown Toenails
Plantar Warts
Swelling in Ankles/Feet
Tired feet

CONSENT:

I certify that the above information is true and correct to the best of my knowledge. I give my permission to the doctor to administer and perform such procedures as may be deemed necessary in the diagnosis and/or treatment of my feet.

Patient Signature _____ Date _____/_____/_____

Podiatric Fall Risk Assessment Form

Patient Name: _____ Date _____

Circle appropriate score for each section and total score at bottom.

Parameter		Score	Patient Status/Condition
A.	Vestibular (Dizziness)	0	No complaints of dizziness
		2	Intermittent complaints of dizziness
		4	Dizziness that interferes with ADLs
B.	History of Falls (past 12 months)	0	No falls
		2	1-2 falls or near falls
		9	3 or more falls or near falls
	Demographics	1	Female
		2	Female > 65 years
D.	Vision Status	0	Adequate (w/ or w/o glasses)
		2	Poor (w/ or w/o glasses)
		4	Legally blind
E.	Gait and Balance	------	Have patient stand on both feet w/o any type of assist then have walk: forward, thru a doorway, then make a turn. (Mark all that apply.)
		0	Normal/safe gait and balance.
		1	Balance problem while standing.
		1	Balance problem while walking.
		1	Decreased muscular coordination.
		1	Change in gait pattern when walking through doorway.
		1	Jerking or unstable when making turns
		1	Requires assistance (person, furniture/walls or device).
F.	Ankle Strength/ Range of Motion	0	Normal ankle strength and ROM within normal limits
		2	Moderate limitation of ankle joint range of motion and strength
		4	Significant ankle joint instability and weakness
G.	Medications	------	Based upon the following types of medications: anesthetics, antihistamines, cathartics, diuretics, antihypertensives, antiseizure, benzodiazepines, hypoglycemics, psychotropics, sedative/hypnotics.
		0	None of these medications taken currently or w/in past 7 days.
		2	Takes 1-2 of these medications currently or w/in past 7 days.
		4	Takes 3-4 of these medications currently or w/in past 7 days.
		1	Mark additional point if patient has had a change in these medications or doses in past 5 days.
H.	Predisposing Diseases	------	Based upon the following conditions: neuropathy, hypertension, vertigo, CVA, Parkinson's Disease, loss of limb(s), seizures, arthritis, osteoporosis,
		0	None present.
		2	1-2 present.
		4	3 or more present.
I.	Get Up and Go	0	Able to rise in a single motion (no loss of balance with steps)
		2	Pushes up, successful in one attempt
		4	Multiple attempts to get up, but successful
J.	Walk and Talk	5	Inability to maintain normal gait pattern while walking
		8	Must stop walking in order to speak
TOTAL SCORE			A score of 10 or more indicates high-risk for falls. If score is 10 or more, complete page 3.

indicates primary consideration for MBB