

Tri-County Foot & Ankle Associates, Inc.

Dr. Mark W. Scott, D.P.M. • Dr. Hung S. Le, D.P.M.

Diabetic Foot Care • Diabetic Wound Care • Bunions/Hammer Toes • Heel Pain
Ingrown Nails • Fracture Care • Sports Medicine • Pediatric Foot Care

REGISTRATION AND HISTORY

1. PATIENT INFORMATION

Date _____ / _____ / _____

Patient _____

Address _____

City State Zip

Sex: M F Age _____ Birthdate _____ / _____ / _____

Single Married Widowed Separated Divorced

Patient SS# _____

Occupation _____

Employer _____

Employer Address _____

Employer Phone _____

Spouse's Name _____

Birthdate _____ SS# _____

Occupation _____

Spouse's Employer _____

Whom may we thank for referring you? _____

2. INSURANCE

Who is responsible for this account? _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

Is patient covered by additional insurance? Yes No

Subscriber Name _____

Birthdate _____ SS # _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (*or my dependent*) have insurance coverage with _____ and assign directly to DR. Scott / Dr. Lee, all insurance benefits, if any otherwise 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 either to me or on my behalf to DR. Scott / Dr. Lee for any services furnished me by that physician. 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 or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in 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 cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

Relationship _____

Date _____

3. PHONE NUMBERS

Home _____ Work _____ Ext _____

Cell _____

Email _____

Best time and place to reach you _____

IN CASE OF EMERGENCY, CONTACT

Name _____ Relationship _____

4. PODIATRIC HISTORY

What is the chief complaint for which you came to be treated? (Include foot, ankle, knee, thigh, and hip complaints.)

Have you ever been to a Podiatrist before?

Yes No If yes, please list below:

Name _____

Last Visit _____

Is there any personal or family history of diabetes? Yes No

If Yes, which family member/members?

Your occupation _____

Athletic activities in which you participate
(please list and indicate frequency)

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

Ankle Pain Yes No

Athlete's Foot Yes No

Bunions Yes No

Corns and Calluses Yes No

Cramps or Numbness in Yes No

Feet or Legs

Flat Feet Yes No

Foot or Leg Cramps Yes No

Heel Pain Yes No

Ingrown Toenails Yes No

Plantar Warts Yes No

Swelling in Ankles/Feet Yes No

Tired Feet Yes No

5. MEDICAL HISTORY

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

- | | | | | | |
|---|--|-----------------------|--|--------------------------|--|
| AIDS/HIV | <input type="checkbox"/> Yes <input type="checkbox"/> No | Diabetes | <input type="checkbox"/> Yes <input type="checkbox"/> No | Psychiatric Care | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Allergies to Anesthetics | <input type="checkbox"/> Yes <input type="checkbox"/> No | Ear Problems | <input type="checkbox"/> Yes <input type="checkbox"/> No | Radiation Treatment | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Allergies to Medicine
or Drugs | <input type="checkbox"/> Yes <input type="checkbox"/> No | Epilepsy | <input type="checkbox"/> Yes <input type="checkbox"/> No | Rash | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Anemia | <input type="checkbox"/> Yes <input type="checkbox"/> No | Eye Problems | <input type="checkbox"/> Yes <input type="checkbox"/> No | Respiratory Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Angina | <input type="checkbox"/> Yes <input type="checkbox"/> No | Fainting | <input type="checkbox"/> Yes <input type="checkbox"/> No | Rheumatic Fever | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Arthritis | <input type="checkbox"/> Yes <input type="checkbox"/> No | Foot or Leg Cramps | <input type="checkbox"/> Yes <input type="checkbox"/> No | Shortness of Breath | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Artificial Heart Valves
or Artificial Joints | <input type="checkbox"/> Yes <input type="checkbox"/> No | Gout | <input type="checkbox"/> Yes <input type="checkbox"/> No | Sinus Problems | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Asthma | <input type="checkbox"/> Yes <input type="checkbox"/> No | Headaches | <input type="checkbox"/> Yes <input type="checkbox"/> No | Special Diet | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Back Problems | <input type="checkbox"/> Yes <input type="checkbox"/> No | Heart Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No | Stroke | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Bleeding Disorders | <input type="checkbox"/> Yes <input type="checkbox"/> No | Hemophilia | <input type="checkbox"/> Yes <input type="checkbox"/> No | Swelling in Ankles, Feet | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Cancer | <input type="checkbox"/> Yes <input type="checkbox"/> No | Hepatitis or Jaundice | <input type="checkbox"/> Yes <input type="checkbox"/> No | Swollen Neck Glands | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Chemical Dependency | <input type="checkbox"/> Yes <input type="checkbox"/> No | High Blood Pressure | <input type="checkbox"/> Yes <input type="checkbox"/> No | Tired Feet | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Chest Pain | <input type="checkbox"/> Yes <input type="checkbox"/> No | Kidney Problems | <input type="checkbox"/> Yes <input type="checkbox"/> No | Tuberculosis | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Chronic Diarrhea | <input type="checkbox"/> Yes <input type="checkbox"/> No | Liver Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No | Ulcers | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Circulatory Problems | <input type="checkbox"/> Yes <input type="checkbox"/> No | Low Blood Pressure | <input type="checkbox"/> Yes <input type="checkbox"/> No | Varicose Veins | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| | | Nervous Problems | <input type="checkbox"/> Yes <input type="checkbox"/> No | Venereal Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| | | Phlebitis | <input type="checkbox"/> Yes <input type="checkbox"/> No | Weight Loss, unexplained | <input type="checkbox"/> Yes <input type="checkbox"/> No |

Surgeries you have had _____

Hospitalization other than for the surgeries listed _____

Family Physician _____ Last visit date _____

Are you now, or have you been, under any other doctor's care for any reason over the past two years? Yes No

If yes, please explain _____

6. ALLERGIES *check all that apply*

- | | | | |
|-------------------------------------|--|--|--------------------------------|
| Food: | Drug: | Environmental: | Other Allergies: |
| <input type="checkbox"/> Gluten | <input type="checkbox"/> Anticoagulant Therapy | <input type="checkbox"/> Adhesive/Tape | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Milk/Dairy | <input type="checkbox"/> Aspirin | <input type="checkbox"/> Cats | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Peanut | <input type="checkbox"/> Codeine | <input type="checkbox"/> Dogs | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Seafood | <input type="checkbox"/> Demerol | <input type="checkbox"/> Pollen | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Soy | <input type="checkbox"/> Iodine | <input type="checkbox"/> Mold | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Tree Nuts | <input type="checkbox"/> Local Anesthetics | <input type="checkbox"/> Perfume | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Eggs | <input type="checkbox"/> Novacaine | <input type="checkbox"/> Latex | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Sulfites | <input type="checkbox"/> Penicillin | <input type="checkbox"/> Nickle | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Wheat | <input type="checkbox"/> Sulfa Drugs | <input type="checkbox"/> Dust | <input type="checkbox"/> _____ |

7. LIFESTYLE

- Tobacco Use:**
- Never
- Previously; quit _____ yrs. ago
- Current; _____ packs per day
- Alcohol Use:**
- Never Daily
- Rarely
- Moderate

CONSENT

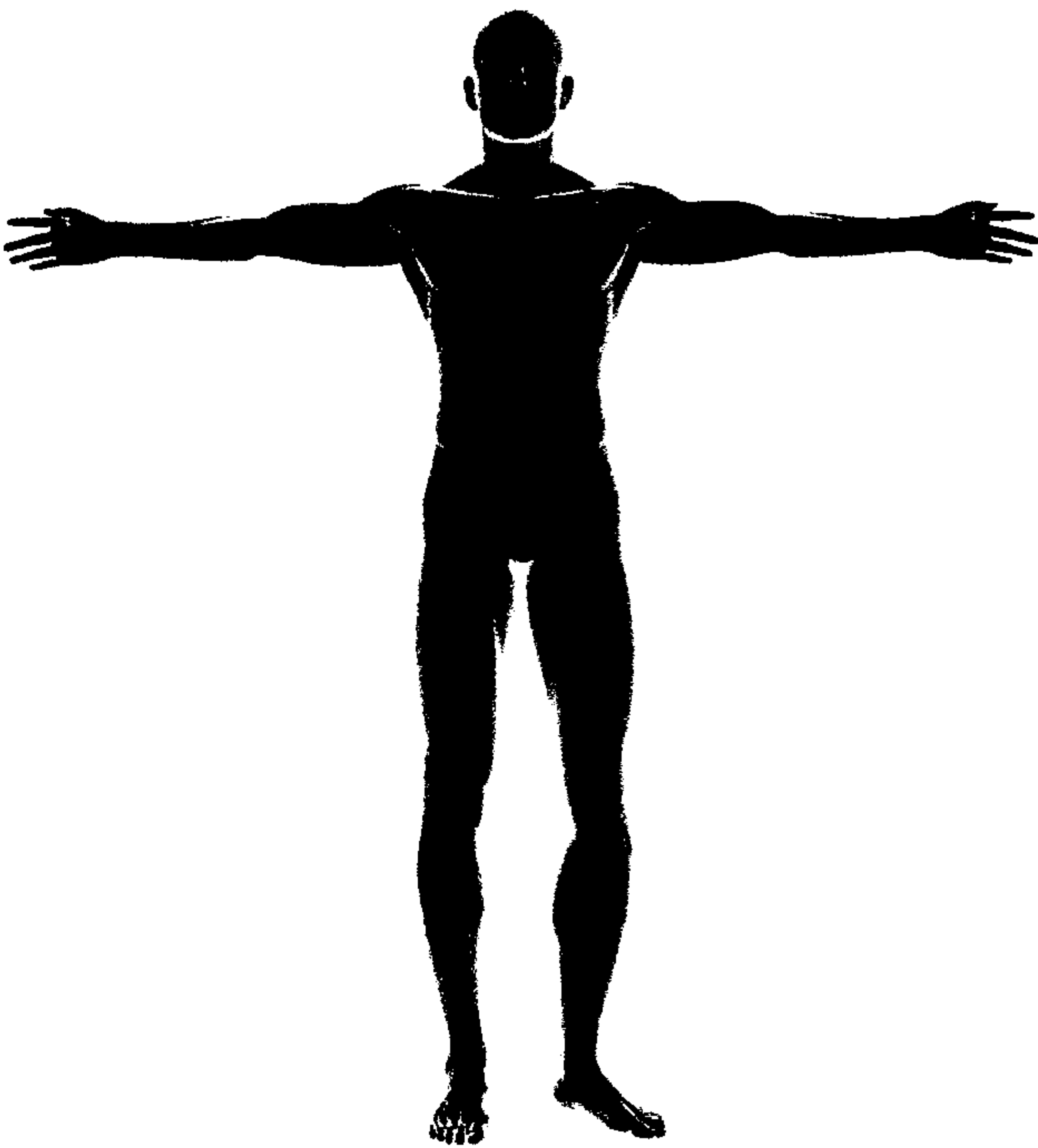
I certify that the above information is true and correct to the best of my knowledge. I give my permission to the doctor to administer and perform such procedures as may be deemed necessary in the diagnosis and/or treatment of my feet.

Patient's Signature _____ Date _____

9. PAD Assessment (Peripheral Artery Disease)

Peripheral Artery Disease (PAD) is a common circulation problem in which arteries carrying blood to the legs are not functioning well or become narrowed or clogged due to a build-up of plaque. Fill out the questionnaire so Dr. Recko can evaluate whether you may be at risk or have symptoms of PAD.

Circle Yes or No on the following questions and check all boxes that apply:

<p>1 Have you ever been diagnosed with Peripheral Vascular Disease or been diagnosed as having poor circulation? YES NO</p>	<p>6 If you have pain, does the pain subside with rest? YES NO</p>
<p>2 Have you ever had surgery, balloon procedures or stents in your heart, kidneys, belly, legs, or arms? YES NO If yes, dates: _____</p>	<p>7 Do your feet or toes bother you most nights while lying in bed, with relief when they are dangled at the edge of the bed? YES NO</p>
<p>3 When you walk, do you experience aching, cramping or pain in your legs, thighs, or buttocks? YES NO</p>	<p>8 Do you have any painful sores or ulcers on legs or feet that do not heal? YES NO</p>
<p>4 If you answered Yes to #3, when do you feel the pain:</p> <p><input type="checkbox"/> After walking 1 block</p> <p><input type="checkbox"/> Climbing a flight of stairs</p> <p><input type="checkbox"/> After walking 100 yards</p> <p><input type="checkbox"/> Walking at increased speed</p>	<p>9 Are your legs discolored or bluish? YES NO</p>
<p>5 If you answered Yes to #3, circle the area(s) of the body on the diagram below where you feel pain.</p> 	<p>10 Check all that apply:</p> <p><input type="checkbox"/> I am a current smoker</p> <p><input type="checkbox"/> I have a history of smoking</p> <p><input type="checkbox"/> I have diabetes</p> <p><input type="checkbox"/> I have a family history of diabetes</p> <p><input type="checkbox"/> I have high cholesterol</p> <p><input type="checkbox"/> I have a family history of high cholesterol</p> <p><input type="checkbox"/> I have high blood pressure/hypertension</p> <p><input type="checkbox"/> I have a family history of high blood pressure/hypertension</p> <p><input type="checkbox"/> I have/had coronary artery disease (CAD)/heart attack</p> <p><input type="checkbox"/> I have a family history of coronary artery disease (CAD)/heart attack</p> <p><input type="checkbox"/> I have had a stroke/mini-stroke/TIA</p> <p><input type="checkbox"/> I have a family history of stroke/mini-stroke/TIA</p>

10. OFFICE POLICY

Thank you for choosing our office to provide you with medical care. We are committed to serving you with skill and high quality care. The medical services provided by our office are services you have elected to receive imply some financial responsibility on your part.

INSURANCE: We file insurance claims as a courtesy to our patients. We file primary and secondary insurance carriers only. Each individual therapist/physician has contracts with various insurance companies. Please check and see if your company is covered by your provider. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions that you have.

COPAYMENTS/DEDUCTIBLES: All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company.

PRE-APPROVALS: You, the patient or the insured is responsible for the initial call to your insurance company if pre-approval is required. This is the policy of the insurance company. We are responsible for any additional sessions that may be needed for your continued treatment.

CANCELLATIONS: We require 24 hour notice on all cancellations so we may have the opportunity to schedule another patient that may need an appointment. **There is a charge** for any missed appointments or cancellations with less than 24 hours notice.

PAYMENTS: We accept the following payment methods: Cash, Check, and VISA/MasterCard. Please let the office know if you have any difficulties in resolving you bill.

RETURN CHECK FEE: An additional \$30.00 will be added to your statement if the check is returned for insufficient funds.

If you should have any questions regarding our policies, just let us know.

Patient Signature

Date

Witness

Date

ACKNOWLEDGEMENT FORM: I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

Name _____

Birthdate ____ / ____ / ____

Patient Signature

Date

USE AND/OR DISCLOSURE AUTHORIZED: Please list the people/organizations that you are authorizing to use and/or disclose the protected health information. Please describe in detail the protected health information you are authorizing each person/organization to use and/or disclose.

Use other side if you need more room.

