Golden Triangle Foot & Ankle Specialists

Welcome to our Office. *Please fill this form out* ***COMPLETELY***. Thank you.

Date		Social Security Number		
First Name		Last Name		Middle Initial
Birthdate (month/day/year)	Gender Male Female		Marital Status Single Married Widowed Divorced	
Address	Apt #	City	State	Zip
Home Phone ( )	Work Phone ( )		Cell Phone ( )	
Emergency Contact			Emergency Phone ( )	
Employer Name			Job Title	
Referring Doctor	Address/City/State/Zip		Phone Number ( )	
Primary Care Doctor	Address/City/State/Zip		Phone Number ( )	
E-mail address				

Primary Insurance Information	**Secondary Insurance Information**
Policy Holder First Name Middle Initial Last Name	Policy Holder First Name Middle Initial Last Name
Policy Holder SSN Policy Holder Birthdate	Policy Holder SSN Policy Holder Birthdate
Policy Holder Address city, state, zip	Policy Holder Address city, state, zip
Name of Insurance Co	Name of Insurance Co
Policy ID Group #	Policy ID Group #
Address for Claim Submission	Address for Claim Submission
Effective Date / /	Effective Date / /
Do you have a co-pay? No Yes, amount $	Do you have a co-pay? No Yes, amount $
Is a Referral required? Yes No (please circle)	Is a Referral required? Yes No (please circle)

Responsible Party	
Name	SSN
Address	
Relationship to Responsible Party (circle one) Self Spouse Child Other	

I hereby authorize the release of any medical information necessary to process this claim and hereby assign to the physician all payments for medical services rendered to my dependents or myself. I understand that it is as a courtesy that the doctor accepts my insurance for payment and that if for any reason they do not pay my bill that I am responsible. This Practice accepts personal checks. In the event that a check 'bounces' (i.e. insufficient funds exist to cover the check) a fee of $30 will be applied. By signing below, I acknowledge and agree to abide by this policy.

Signature ____________________________________ **Date**_____________ **Time**___________

(Parent Signature if Patient is under 18 years of age)

Name **Date of Birth**

Podiatric History

Chief Complaint (reason for your visit today)	**Describe type of Pain** (circle all that apply)
Describe:	Dull Aching Sharp
	Shooting Throbbing Burning
	Tingling Cramping Numbness
Did this happen at work? **(circle)** **Yes** **No**	Other (describe)
Location: Right Left Both	**Duration** (How long have your symptoms been present)
(circle) Foot Ankle Leg Knee	#______ Days Weeks Months Years
Onset: Slow Sudden Traumatic	**If Traumatic**: Auto Worker's Comp Other
Has pain become: Better Worse Same	**Symptoms are worse:** AM PM Night Day
What aggravates your condition?	**Previous Treatments:**

Who referred you to our office?

Name of Primary Physician: Date of last visit:

May we contact your physician about your care? Yes No (please circle)

Have you ever seen a Podiatrist? No Yes If Yes, who? When?

Medical History

Y N AIDS / HIV	Y N Depression	Y N Leg Cramps
Y N Anemia	Y N Diabetes	Y N Liver Disease
Y N Anxiety	How long?	Y N Low Blood Pressure
Y N Arthritis (type)	Y N Emphysema	Y N Neuropathy
Y N Artificial Heart Valve	Y N Eye Problems	Y N Pacemaker
Y N Artificial Joint	Y N Fibromyalgia	Y N Phlebitis
Y N Asthma	Y N Foot Cramps	Y N Psoriasis
Y N Back Problems	Y N Gastric Reflux	Y N Rheumatic Fever
Y N Bleeding Disorder	Y N Gout	Y N Schizophrenia
Y N Bipolar Disorder	Y N Headaches	Y N Seizures / Epilepsy
Y N Blood Clot / DVT	Y N Heart Attack	Y N Shortness of Breath
Y N Bypass Surgery	Y N Heart Murmur	Y N Stroke
Y N Cancer Type?	Y N Heart Failure	Y N Thyroid Problems Type?
	Y N Hemophilia	
Y N Chemical Dependency	Y N Hepatitis	Y N Tuberculosis
Y N Chest Pain	Y N High Blood Pressure	Y N Ulcers (stomach)
Y N Circulatory Problems	Y N Kidney Problems	Y N Varicose veins

Women: Are you Pregnant? Yes No Breastfeeding? Yes No

Name **Date of Birth**

Family History

Please list **WHICH** family member(s) in the space provided (mother, father, grandparent, sibling)

Heart Disease	Gout
Diabetes	Arthritis
High Blood Pressure	Neuropathy
Stroke	Bleeding Disorder
Varicose Veins	Foot Problems

Mother:	Living Deceased	Age Age	Cause:
Father:	Living Deceased	Age Age	Cause:
Brother(s) :	Living Deceased	Age Age	Cause:
Sister(s) :	Living Deceased	Age Age	Cause:

Review of Systems

Circle all **CURRENT** Problems

Constitutional	Fever, weight loss, weakness, fatigue
Skin	Dry skin, excessive sweating, itching, sores, rashes, color change
Hematological	Swollen glands, easy bruising, previous blood transfusion
HEENT	Headaches, sinus problems, allergies, nosebleeds, visual or hearing problems, wear contacts or glasses, gum disease, problems with teeth, sleep apnea snoring
Chest/Respiratory	Cough, shortness of breath, wheezing, bronchitis, pneumonia
Cardiovascular	Heart trouble, chest pain/angina, swelling of legs/feet, irregular heartbeat
Abdominal	Liver disease, hepatitis, jaundice, gallbladder problems, irritable bowel syndrome, colitis, polyps, diverticulitis, heartburn, peptic ulcer, diarrhea, constipation, dark stools
Genitourinary	Kidney stones, kidney disease, bladder dysfunction, pain with urination, blood in urine, ovarian cysts, uterine fibroids, hernia
Endocrine	Thyroid problems, hormonal changes, diabetes, excessive thirst, recent weight loss or gain, heat or cold intolerance
Musculoskeletal	Neck or low back pain, joint pain, muscle pain, stiffness, hip, shoulder or knee problems, carpal tunnel
Neurological	Seizures, fainting spells, blackouts, weakness, dizziness, tremors, gait problems, memory problems, numbness, burning pain, cramping in foot and/or leg, concentration difficulty, depression, anxiety

Age: Height: Weight: Shoe Size:

Name **Date of Birth**

Medications

Please list ALL prescriptions, over-the-counter medications and vitamins (Or give us a list to copy)

Medication Name	Dose	Frequency

Preferred Pharmacy **Pharmacy Phone #**

Allergies

Do you have any allergies or adverse reactions to the following? If a reaction, list what type.

N Y	Local Anesthesia	N Y	General Anesthesia
N Y	Aspirin	N Y	Latex
N Y	Anti-Inflammatory	N Y	Tape / Adhesives
N Y	Penicillin	N Y	Iodine
N Y	Sulfa	N Y	Betadine
N Y	IVP Dye	N Y	Codeine
N Y	Tetanus	N Y	Steroids
Other antibiotics (name)			
Other medications (name)			

Surgical and Hospitalization History

List ALL previous surgeries and hospitalizations with approximate date/year.

Social History

Occupation
Do you Smoke? N Y How many packs per day?
Did you smoke previously? N Y How many packs per day?
Do you drink alcohol? N Y What type? How many per day? Week?
Do you use illicit drugs? N Y What type? How often?

The information provided by me is true and correct to the best of my knowledge.

Signature ___________________________________ Date____________ Time_________
(Parent Signature if Patient is under 18 years of age)

Golden Triangle

Foot & Ankle Specialists

Dr. Neil A. Burrell   Dr. Debra J. Lusk
Dr. Kolby S. White   Dr. Leigh A. Harvey

I give my written permission to release my protected health information to the following:

______________________________ Relation____________________

______________________________ Relation____________________

______________________________ Relation____________________

______________________________ Relation____________________

I have reviewed this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document at my request.

______________________________________ ____________________

Signature of Patient or Personal Representative   Date

____

Printed Name of Patient of Personal Representative

____

Relationship to Patient if Personal Representative

Golden Triangle
Foot & Ankle Specialists

Financial Policy

Referrals

It is **YOUR** responsibility to obtain a referral from your Primary Care Physician **IF** your insurance company requires a referral. If a referral is required, your insurance company will not pay for your visit without that referral. You would be required to pay for the visit.

Toenail Trimming

Medicare does ***not*** pay for toenail trimming unless the patient meets specific criteria. If you ***do not*** meet the criteria and would like to have your toenails trimmed, we will collect **$40.00** at the time of service.

We do not treat work-related injuries or third-party claims (such as auto accidents)

Secondary Insurance

We are happy to file your visit with your secondary insurance, but we must have this information **BEFORE** you see the Doctor. You are responsible for any balance after the claim has been finalized.

Office Procedures

Procedures in the office are usually *not* covered under your office visit co-pay. Typically, they are applied to your deductible. This may include services such as surgical procedures in the office or in a surgical facility, Ingrown toenail procedures, Custom Molded Orthotics, X-rays, Ultrasounds, Injections, or Durable Medical Equipment. Your covered medical expenses are based on the contract between **You** and **Your** insurance carrier. If the procedure or service is applied to your deductible then the payment is your responsibility.

Our office will **try** to verify your insurance coverage and collect the necessary co-pay, deductible and/or co-insurance amounts. Although we may **estimate** what your insurance company will pay, they make the **final determination** regarding your benefits. Therefore, it is possible that you may be responsible for more than we initially estimate.

We will collect the doctor's fee for surgeries that will be performed in a surgical facility or hospital at the time the surgery is scheduled.

We will send you a monthly statement if you have a balance on your account. Unless we approve other arrangements in writing, the balance on your statement is due and payable when the statement is issued. Delinquent balances will be sent to a collection agency.

I authorize the release of any medical information necessary to pay this claim. I authorize Dr. Burrell, Dr. Lusk, Dr. White or Dr. Harvey to apply for benefits on my behalf for services rendered. I request that payment from my insurance company be made directly to Dr. Burrell, Dr. Lusk, Dr. White or Dr. Harvey. I certify that the information I have furnished with regard to my insurance coverage is correct. I permit a copy of this authorization to be used in place of the original.

Signature ________________________________ Date ___________ Time__________

(Parent Signature if Patient is under 18 years of age)