

FOOT AND ANKLE WELLNESS CENTER



DR. LEONARD E. VEKKOS

NAME _____
LAST FIRST MIDDLE

ADDRESS _____
STREET APT# CITY STATE ZIP

HOME PHONE () WORK PHONE () CELL PHONE ()

AGE DATE OF BIRTH SOCIAL SECURITY NO SEX M F

YOUR OCCUPATION EMPLOYER

EMPLOYER'S ADDRESS EMPLOYER PHONE

EMERGENCY CONTACT ()

MARITAL STATUS (CIRCLE) S M W D NAME OF SPOUSE _____

PRIMARY INSURANCE	POLICY ID NO.	GROUP NO.
SUBSCRIBER	DOB	SOCIAL SECURITY NO.
HMO	PPO	
SECONDARY INSURANCE	POLICY ID NO.	GROUP NO.
SUBSCRIBER	DOB	SOCIAL SECURITY NO.
HMO	PPO	
GUARANTOR	()	
ADDRESS		
RELATIONSHIP TO PATIENT		

PRIMARY CARE PHYSICIAN PHONE ()

PHYSICIAN'S HOSPITAL AFFILIATION DATE OF LAST VISIT

WHO REFERRED YOU TO OUR OFFICE

WHAT IS YOUR FOOT PROBLEM

HOW LONG HAVE YOU HAD THIS PROBLEM HAVE YOU BEEN TREATED FOR IT? YES

NO

BY WHOM?

IS YOUR FOOT PROBLEM THE RESULT OF A WORK-RELATED INJURY? YES NO

PATIENT/GUARDIAN SIGNATURE DATE

FOOT AND ANKLE WELLNESS CENTER



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PATIENT AGREEMENTS AND AUTHORIZATIONS

CONSENT FOR TREATMENT. I hereby consent to the treatment provided by Foot and Ankle Wellness Center and its employees or designees. I authorize the physical health care services deemed necessary or advisable by my caregivers to address my needs. _____
(initial)

AUTHORIZATION FOR RELEASE OF PERSONAL HEALTH INFORMATION.

I authorize use and disclosure of my personal health information for the purposes of diagnosing or providing treatment to me, obtaining payment for my care, or for the purposes of conducting the healthcare operations of Foot and Ankle Wellness Center. I authorize Foot and Ankle Wellness Center to release any information required in the process of applications for financial coverage for the services rendered. This authorization provides that Foot and Ankle Wellness Center may release objective clinical information related to my diagnoses and treatment, which may be requested by my insurance company or its designated agent. _____
(initial)

ASSIGNMENT OF INSURANCE BENEFITS/PAYMENT GUARANTEE/COLLECTION FEE.

I authorize payment to be made directly to Foot and Ankle Wellness Center for insurance benefits payable to me. I understand that I am financially responsible to Foot and Ankle Wellness Center for any covered or non-covered services, as defined by my insurer. I understand that if my account balance becomes overdue and the overdue amount is referred to a collection agency, I will be responsible for the costs of collection including reasonable attorney fees. _____
(initial)

PRIVACY POLICY. I acknowledge having received the Foot and Ankle Wellness Center's, "Notice of Privacy Policies". My rights, including the right to see and copy my record, to limit disclosure of my health information, and to request an amendment to my record, are explained in the Policy. I understand that I may revoke in writing my consent for release of my health care information, except to the extent that Foot and Ankle Wellness Center has already made disclosures with my prior consent. _____
(initial)

HMO POLICIES, I understand that it is my responsibility to obtain referrals from my primary care physician. If I do not supply Foot and Ankle Wellness Center with a referral for any appointment where one is required, I understand that I will be responsible for payment in full at the time of service. _____
(initial)

RETURNED CHECKS, I understand that I will be charged \$30 for any returned check from the bank for "non-sufficient funds". _____
(initial)

MEDICAL RECORDS REQUESTS, I understand there will be, at minimum, a \$25 fee for requests for medical records from any party other than my health insurance company and that this fee will be paid prior to the records being released. An additional fee of \$10 will be charged for copies of xrays in either disc or photo format.

(initial)

MEDICAL INFORMATION

Past Medical History

Have you ever had any of the following?

- | | | | |
|--|---|--|---|
| <input type="checkbox"/> Measles | <input type="checkbox"/> Asthma | <input type="checkbox"/> Fevers over 103° | <input type="checkbox"/> Psychological Problems |
| <input type="checkbox"/> Mumps | <input type="checkbox"/> Balance Problems | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Sexually Transmitted Disease |
| <input type="checkbox"/> Chickenpox | <input type="checkbox"/> Bladder Problems | <input type="checkbox"/> High/Low Blood Pressure | <input type="checkbox"/> Skin Problems |
| <input type="checkbox"/> Whooping Cough | <input type="checkbox"/> Blood Clots | <input type="checkbox"/> Hearing Loss | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Scarlet Fever | <input type="checkbox"/> Bowel Problems | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Swelling of Feet/Ankles |
| <input type="checkbox"/> Diphtheria | <input type="checkbox"/> Cancer | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Smallpox | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Digestion Problems | <input type="checkbox"/> Migraine Headaches | <input type="checkbox"/> Ulcer |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Numbness/Tingling | <input type="checkbox"/> Varicose Veins |
| <input type="checkbox"/> AIDS or HIV+ | <input type="checkbox"/> Ear/Nose Throat Problems | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Vision Problems |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Polio | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Fainting | <input type="checkbox"/> Prolonged Bleeding | _____ |

HEIGHT _____ WEIGHT _____

Previous Hospitalizations/Surgeries/Serious Illness (and When?) _____

What medications &/or vitamins are you taking now and what dose? _____

(Women) Are you pregnant? Yes No

Are you taking Birth Control Pills? Yes No

Are you under the care of a physician? Yes No If yes, for what reason (s)?

Social History

Do you live alone? Yes No For how long? _____

Do you have children? Yes No If yes, how many? _____

Do you exercise? Yes No If yes, how often? _____ What kind of exercise? _____

Are you on a special diet? Yes No If yes, what kind? _____

Do you smoke? Yes No If yes, how many packs per day? # ____ for # ____ years.

If no, when did you quit? _____ How many packs had you smoked? # ____ per day for # ____ years.

Do you drink alcohol? Yes No How much _____ Daily _____ Weekly _____ Monthly _____ Yearly

Signature _____ Date _____ Reviewed by: _____