HILLSIDE
Foot&Ankle

PATIENT INFORMATION FORM (PLEASE PRINT)

Date: ___/___/___ Social Security #: _____

Patient Name: _____ _____ ___ Date of Birth: ___/___/___ Sex: M F
Last First MI

Home Address: _____ City/State: _____ Zip: _____

Home Phone: (_____) _____-_____ Yes No May we leave a message?
Cell Phone: (_____) _____-_____ Yes No May we leave a message?
Email: _____
If you would like us to release medical information to family members or other individuals, please list their name and relationship: _____ _____
_____ _____

Primary Language: _____ Ethnicity: ___Not Specified ___Hispanic/Latino ___Not Hispanic / Latino
Race: ___White ___Amer. Indian/Alaska Native ___Asian ___Black/African Amer. ___Native Hawaiian/Pacific Is.
___Not Specified

Emergency Contact: _____ Relationship: _____ Phone #: (___) ____-_____

Primary Care Doctor: _____ Date last seen: _____ Pharmacy: _____

Who is responsible for payment? _____ Relationship to patient? _____
Address: _____ City/State: _____ Zip: _____
Phone #: (_____) _____-_____ Birthdate: _____ Social Security # _____

Do you have a legal guardian or healthcare power of attorney? Yes No
If yes, Name: _____ Relationship: _____ Phone #: (___) ____-_____

Whom may we thank for referring you to us? _____

Insurance Information

Primary Insurance Company Name: _____
Policy #: _____ Group #: _____
Subscriber: _____ Subscribers Birthdate: _____ SS#: _____

Secondary Insurance Company Name: _____
Policy #: _____ Group #: _____
Subscriber: _____ Subscribers Birthdate: _____ SS#: _____

Social History

Marital Status: ☐ Single ☐ Married ☐ Partnered ☐ Separated ☐ Divorced ☐ Widowed

Use of Alcohol: ☐ Never ☐ No longer use ☐ History of alcohol abuse
☐ Current Use - Type _____ ☐ Rare ☐ Occasional ☐ Moderate ☐ Daily

Use of Tobacco: ☐ Never ☐ Quit – how long ago? _____ ☐ Smoke ____ packs/day for ___yrs

Use of Recreational Drugs: ☐ Never ☐ Quit – How long ago? _____ Type _____
☐ Current Use - Type _____ ☐ Rare ☐ Occasional ☐ Moderate ☐ Daily

Employer: _____ Occupation: _____ Phone #: (_____) _____-_____
How much are you on your feet at work? ☐ 10% ☐ 25% ☐ 50% ☐ 75% ☐ 100%

OVER

Family History

Please indicate, using the following letters: **F**(Father), **M**(Mother), **B**(Brother), **S**(Sister), **D**(Daughter), **C**(Son) who in your family has a history:

Diabetes_____ Cancer_____ Heart Disease_____ High Blood Pressure_____
Stroke_____ Coronary Artery Disease_____ Thyroid Disease_____
Rheumatoid Arthritis_____ Other _____

Your Medical History

Height:_____ Weight:_____ Shoe Size:_____

Allergies: ☐ None Known ☐ Penicillin ☐ Medications _____
☐ Tape ☐ Latex ☐ Shellfish ☐ Iodine ☐ Anesthesia _____
☐ Foods _____ ☐ Other _____

Place a check mark in the box to indicate if you have ever had any of the following?

	Yes	No		Yes	No		Yes	No
Acid Reflux			Fibromyalgia			Mitral Valve Prolapse		
Anemia			Gout			Neuropathy		
Arthritis			Heart Attack			Open Sores		
Asthma			Heart Disease/Failure			Pneumonia		
Back Trouble			Hepatitis			Polio		
Bladder Infections			HIV+/AIDS			Rheumatic Fever		
Abnormal Bleeding			High Blood Pressure			Skin Disorder		
Blood Clots			High Cholesterol			Sleep Apnea		
Blood Transfusion			Kidney Disease			Stomach Ulcers		
Bronchitis/Emphysema			Liver Disease			Stroke		
Cancer			Low Blood Pressure			Thyroid Disease		
Diabetes			Migraine Headaches			Tuberculosis		
Other Conditions:								

List all medications and dosages you are currently taking (Include prescriptions, over-the-counter meds and herbal supplements):

_____ _____ _____
_____ _____ _____
_____ _____ _____

List all prior surgeries:

Type of Surgery	Date	Type of Surgery	Date	Type of Surgery	Date

List all prior hospitalizations (other than for surgery)in the last 12 months:

Reason	Date	Reason	Date	Reason	Date

Current Problem

What specific problem brings you to our office today? _____

Where is the pain/problem located? _____

How long ago did this problem first start? _____ Days / Weeks / Months / Years

Did your pain or problem: ☐ Begin all of a sudden ☐ Gradually develop over time

How would you describe your pain? ☐ No pain ☐ Sharp ☐ Dull ☐ Aching ☐ Burning
☐ Radiating ☐ Itching ☐ Stabbing ☐ Other _____

How would you rate your pain on a scale from 0 to 10? (please circle)
(no pain) 0 1 2 3 4 5 6 7 8 9 10 (worst pain possible)

Since the time your pain or problem began, has it: ☐ stayed the same ☐ become worse
☐ Improved

What makes your pain or problem feel worse? ☐ Walking ☐ Standing ☐ Daily activities
☐ Resting ☐ Dress shoes ☐ High heels ☐ Flat shoes ☐ Any closed toe shoe
☐ Running ☐ Other _____

What makes your pain or problem feel better? _____

What treatments have you had for this problem? _____

How has this problem affected your lifestyle or ability to work? _____

Was this problem caused by an injury? ☐ Yes (describe) _____ ☐ No
If yes, was it a work-related injury? ☐ Yes ☐ No

To the best of my knowledge, I have answered the questions on this form accurately. I understand that providing incorrect information can be dangerous to my health. I understand that it is my responsibility to inform the doctor and office staff of any changes in my medical status.

_____
Print name of Patient, Parent or Guardian

_____ _____
Signature **Date**

Assignment and Release

I, the undersigned certify that I (or my dependent) have insurance coverage with the above noted insurance and assign directly to Hanover Foot & Ankle associates 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 Hanover Foot & Ankle Associates 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 **Date**

HILLSIDE FOOT AND ANKLE ASSOCIATES, LLC

Patient Financial Policy

Your understanding of our financial policies is an essential element of your care and treatment. If you have any questions, please discuss them with our front office staff or office manager.

· As our patient, you are responsible for all authorizations/referrals needed to seek treatment in this office. It is the patient's responsibility to check with their insurance to verify that our providers are participating with their plan. Current and correct Insurance information will need to be provided to office staff. Any charges not covered by the patients Insurance will be the finical responsibility of the patient/ responsible party.

· Unless other arrangements have been made in advance by you, or your health insurance carrier, payment for office services are due at the time of service. We will accept VISA, MasterCard, Discover, cash or check.

· Your insurance policy is a contract between you and your insurance company. As a courtesy, we will file your insurance claim for you if you assign the benefits to the doctor. In other words, you agree to have your insurance company pay the doctor directly. If your insurance company does not pay the practice within a reasonable period, you may be responsible for payment.

· We have made prior arrangements with certain insurers and other health plans to accept an assignment of benefits. We will bill those plans with which we have an agreement and will only require you to pay the co-pay/co-insurance/deductible at the time of service.

· If you have insurance coverage with a plan with which we do not have a prior agreement, we will prepare and send the claim for you on an unassigned basis. This means your insurer will send the payment directly to you. Therefore, all charges for your care and treatment are due at the time of service.

In the event your health plan determines a service to be "not covered," or you do not have an authorization, you will be responsible for the complete charge. We will attempt to verify benefits for some specialized services or referrals; however, you remain responsible for charges to any service rendered. Patients are encouraged to contact their plans for clarification of benefits prior to services rendered.

· Missed appointments are disruptive to our office and deprive others from an appointment to see the doctor. Twenty-four (24) hour cancellation notification is required to avoid a $35 no-show fee per appointment slot. Any procedures taking place in office that are canceled in less than 24 hours or of the case of a no-show will have a $65 fee per appointment slot. Your insurance company does that cover this fee and will be the responsibility of the patient, or responsible party to pay the fee prior to being given any future appointments.

· Past due accounts are subject to collection proceedings. All costs incurred including, but not limited to, collection fees, attorney fees and court fees shall be your responsibility in addition to the balance due this office. Any appointments will not be scheduled until responsible party has paid collections/ office in full.

· There is a service fee of $35.00 for all returned checks. Your insurance company does not cover this fee.

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

Signature of Patient/Responsible Party: _____

Printed Name of Patient/Responsible Party: _____ **Date:** _____