

WESTFIELD FOOT AND ANKLE, LLC

Patient information (Please fill out completely)

Date _____

Last name _____ First name _____ Middle initial _____

Address _____ City _____ State _____ Zip _____

Phone # _____ Cell phone # _____ E-mail _____

Sex F M Marital status S M D W

Date of birth _____ S.S. # _____

What type of problem brings you to our office?

Primary Physician _____ Date last seen _____

Emergency contact _____ Phone # _____

Patient Employer _____ Occupation _____

Address _____ City _____ State _____ Zip _____

Employer's phone # _____

Insurance Co. _____ ID# _____ Group# _____

Address _____ City _____ State _____ Zip _____

Secondary Insurance _____ ID# _____ Group# _____

Address _____ City _____ State _____ Zip _____

Insurance carrier (person whom subscribes to the insurance)

Last name _____ First name _____

Address _____ City _____ State _____ Zip _____

Phone # _____ Date of birth _____ S.S. # _____

Employer _____ Occupation _____

Address _____ City _____ State _____ Zip _____

Employer's phone _____

How did you hear about us?

Live nearby/saw office Friend Family

Newspaper Phonebook Website Physician _____

Other _____

Medications (including vitamins):

Allergies (to medications and foods)and reactions:

Your PARENT’s medical history: M=Mother/F=Father (Please X if they have had any of these conditions)

- M__ F__ Alcoholism
- M__ F__ Anesthesia Problems
- M__ F__ Arthritis
- M__ F__ Cancer

- M__ F__ Diabetes
- M__ F__ Heart Problems
- M__ F__ Neurological Disorder
- M__ F__ Seizures

PAST MEDICAL HISTORY (Please X if you have had these)

Cardiovascular

- Congestive heart failure
- Valve Problems
- Low Blood Pressure
- Murmur
- Stroke
- General Cardiovascular Problems
- Deep Vein Thrombosis/Blood Clot
- High Blood Pressure

Dermatologic

- Candidiasis(yeast infection)
- Cellulitis
- STD
- Itchy Dry Skin
- Keratosis
- Psoriasis
- Fungal Infections
- Raynaud’s phenomenon
- Skin Cancer
- Plantar Warts
- Other Warts

Endocrine

- Diabetes (Type 1 or 2?)
- Hypothyroidism

Gastric/Intestinal

- Cancer
- Colitis
- Crohn’s
- Diverticulitis
- GERD
- Gastritis
- GI bleed
- Liver conditions
- Stomach or bowel problems

GU

- Bladder dysfunction
- Kidney problems
- Dialysis

Hematological

- Anemia
- Leukemia
- Hemophilia
- Bleeding abnormalities
- Lymphoma

Musculoskeletal

- Amputation
- Neoplasm
- Fracture history _____
- Ganglion Cyst
- Gout
- Arthritis(type) _____
- Osteomyelitis
- Osteoporosis

Neurological History

- Alzheimer’s
- Sciatica
- Multiple Sclerosis
- Neuropathy
- Seizure Disorder

Psychiatric

Alcoholism
 Drug abuse

Depression

Dementia

REVIEW OF SYSTEMS (RECENT SYMPTOMS ONLY)

Cardiovascular

arm pain
 chest pressure
 calf cramping

back pain
 cold hands
 high blood pressure

chest pain
 cold feet

Constitutional Symptoms

fever
 chills

dizziness
 nausea

diarrhea
 vomiting

Endocrine

cold intolerance

dry eyes

weight changes

Gastrointestinal

abdominal pain

heartburn

blood in stool

Hematologic/Lymphatic

ankle/foot edema
 bleeding problems

calf pain

bruise easily

Integumentary

athlete's foot
 leg swelling

discoloration
 dry, scaly skin

cyst
 lower leg ulcers

Musculoskeletal

back pain
 muscle pain
 joint pain

joint swelling
 hip pain
 stiffness

foot pain
 neck pain

Neurological

dizziness
 seizures
 tremors

migraines
 tingling

confusion
 headache

Respiratory

chest pain
 shortness of breath

difficulty breathing

chest tightness

Past Surgical History (TYPE of surgery and YEAR surgery was performed)

Social History

Do you smoke _____ Yes ___ No _____ How much _____ for how long _____
Do you drink alcohol _____ Yes ___ No _____ How much _____ for how long _____
How often do you exercise? _____ What type of exercise? _____
What type of activity do you do at work (mostly sitting, standing, both)? _____

PLEASE READ AND SIGN

The above information is correct to the best of my knowledge and I consent to such diagnostic procedures and medical care as deemed necessary by the doctor for my treatment. I also consent to have photographs taken which will be used solely for medical education.

I understand that I am responsible for any charges incurred during any visit or treatment by the doctors and staff of Westfield Foot & Ankle. My insurance company may not cover my charges for the following reasons: I did not bring a referral for this care, the referral did not arrive in time for the visit, my insurance company may not cover the service, my insurance may not be in effect, the charges may be applied to my deductible/co pay. The doctors and staff of Westfield Foot & Ankle will file my insurance when appropriate, but I will be ultimately responsible for all charges. A fee schedule can be obtained upon request.

I understand that payment is due at the time of service with no insurance or for non-covered services and due within 90 days when filed with my insurance company. I understand that late fees and/or interest may be applied to my bill if not paid within the 90 day period.

Patient/Parent/Guardian _____
Date

REQUEST FOR CONFIDENTIAL COMMUNICATIONS

I request that all communications to me (by telephone, mail or otherwise) by Westfield Foot & Ankle and/or its staff be handled in the following manner:

- For written communications:
 - Use address above
 - Use the following address:

- For oral communications:
 - Use the following phone number:

May we leave a message?
 Yes No

AUTHORIZATION FOR TREATMENT & RELEASE OF INFORMATION FOR PODIATRY SERVICE

The resident, legal guardian or health care surrogate, if any hereby authorizes Westfield Foot and Ankle, LLC doctors and staff to examine and treat, if necessary: (i.e. Fungal nails, Ingrown nails, pressure ulcer care, braces, diabetic shoes), _____(name of patient)

This consent may be withdrawn at any time. Withdrawal of consent must be in writing to Westfield Foot and Ankle, LLC doctors and staff. The resident, legal guardian or health care surrogate authorized Westfield Foot and Ankle, LLC doctors and staff to disclose appropriate clinical information to facility staff for purpose of treatment. Clinical information can be released to family members listed here for purposes of treatment.

1. _____

2. _____

3. _____

The resident, legal guardian or health care surrogate, if any, has READ and has had fully explained to him/her, and fully understands the above Authorization for Treatment. No assurance or guarantee has been made to the resident, legal guardian, or health care surrogate, if any, concerning the results, which may be obtained. A fee schedule may be obtained upon request.

ASSIGNMENT OF BENEFITS

In order to submit a claim to us for services under your policy, we must have your authorization to release medical information to your carrier. As a Medicare participating provider, Westfield Foot and Ankle doctors and staff will accept assignment. Even though services may be approved by your insurance there is no guaranty of payments. According to Medicare Guidelines, the provider will always accept the amount that Medicare approves with excess charges to be billed to secondary carriers, including Medigap if applicable.

MEDICARE AUTHORIZATION

I request that payment of authorized benefits may be made to Westfield Foot and Ankle, LLC. I authorize any holder of Medical Information 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 hereby authorize Medicare to furnish to Westfield Foot and Ankle, LLC any information regarding Medicare claims under the Title XVIII of the Social Security Act.

PRIMARY & SUPPLEMENTAL INSURANCE

I hereby authorize the release of any information necessary to file a claim with the insurance company and assign benefits to Westfield Foot and Ankle, LLC doctors and staff. This includes any coverage under Medigap.

For patients with Medicare: Medicare makes payments only after a yearly deductible has been satisfied. For patients with both Medicare and Medicaid: Medicaid does not pay the Medicare annual deductible amount, this will be billed to the patient or responsible party.

For patients with Preferred Senior Care: Preferred Senior Care is not expected to pay for this service. Patient or responsible party agrees to pay all charges not covered by Medicare, Medicaid, Medigap, VA, or other insurance.

Failure to pay charges is agreed to imply discontinuation of this podiatry service.

Signature: _____ Date: _____ Facility: _____

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read if I so chose) and understand the Notice.

Patient Name (Please Print)

Date

Parent or Authorized Representative (if applicable)

Signature