INDIANA FOOT & ANKLE
INDIANAFOOTANKLE.COM

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JASPER — 645 W. 5th St. • Jasper, IN 47546 • 812-634-2778 • Fax: 812-634-2909
EVANSVILLE — 5010 Davis Lant Dr., Suite 1 • Evansville, IN 47715 • 812-858-3800 • Fax: 812-858-3810

Do you have diabetes?	**Y | N**
Are you using hospice or are you in a long-term care facility?	**Y | N**
Do you have Osteoporosis?	**Y | N**
Have you had a Bone Density Study?	**Y | N**
If you are 65+, have you had a fall in the last year?	**Y | N**
If yes, how many?	_____
Did you sustain an injury?	**Y | N**
Do you have Rheumatoid Arthritis?	**Y | N**
Do you use any kind of Tobacco product?	**Y | N**
Do you have high blood pressure?	**Y | N**
If yes, do you have kidney disease?	**Y | N**
Have you been in the hospital within the last year?	**Y | N**
How many times in the past year have you had 5 (for men) or 4 (for women and all adults older than 65 years) or more drinks in a day?	_____

Please provide an updated list of medications we can copy.

_____

Patients Name

_____

Birth Date of Patient

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PATIENT INFORMATION: Date:_____

Last Name:_____ First Name:_____ Middle Initial:____

DOB:_____ Social Security#:_____ Sex: Male or Female

Marital Status: Single Married Widowed Divorced E-Mail Address:_____

Race: White Black Hispanic Other:_____ Ethnicity: Caucasian Hispanic Other:_____

Address:_____

City:_____ State:_____ Zip:_____

Home Phone#:_____ Cell Phone#:_____

Employer Name:_____ Work Phone#:_____

Employer Address:_____

City:_____ State:_____ Zip:_____

Family Doctor Name:_____

Last Visit Date:_____

SPOUSE INFORMATION:

Spouse First & Last Name:_____

Spouse Home Phone#:_____ Cell Phone#:_____

Spouse Social Security#_____

INSURANCE INFORMATION:

Primary Insured Person:_____

Address if different than Patient:_____

Relationship to Patient:_____ Insured DOB:_____ Insured Social Security#_____

Primary Insured Person Employer Name:_____

Primary Insured Person Employer Address:_____

City:_____ State:_____ Zip:_____

Primary Insured Employer Phone#:_____

Secondary Insured Person:_____

Address if different than Patient:_____

Relationship to Patient:_____ Insured DOB:_____ Insured Social Security#_____

Secondary Insured Person Employer Name:_____

Secondary Insured Person Employer Address:_____

City:_____ State:_____ Zip:_____

Secondary Insured Person Employer Phone#:_____

EMERGENCY CONTACT

First & Last Name:_____ Relationship to Patient:_____

Address:_____

City:_____ State:_____ Zip:_____

Home Phone#:_____ Cell Phone#:_____

IF PATIENT IS A MINOR PLEASE FILL OUT:

Father Last Name:_____ First Name:_____

Address if different than Patient:_____

Father Social Security#_____ DOB:_____

Father Employer Name:_____

Father Phone#:_____ Work Phone#:_____

Mother Last Name:_____ First Name:_____

Address if different than Patient:_____

Mother Social Security#_____ DOB:_____

Mother Employer Name:_____

Mother Phone#:_____ Work Phone#:_____

Consent to Contact:

You agree, in order for us to service your account, notify you of information pertaining to your account or medical condition, or for the purposes of collection, we may contact you by telephone at any number provided by you, including wireless telephone numbers. We may also contact you via e-mail or text message using any e-mail address you provide. Methods of contact may include the use of pre-recorded and artificial voice messages and/or use of an automated dialing service.

X_____

Signature of Patient or Responsible Party

Date:_____

Describe what is bringing you to Indiana Foot & Ankle:_____

_____

Where is the problem located? _____

_____

Right Left or Bilateral?_____ What is the severity: (Circle one) Mild Moderate or Severe

Describe your pain: (Burning, tingling, stabbing, sharp etc.)_____

_____

How long has the problem been going on? _____

Are you currently experiencing: Any Chills? Yes or No Weakness? Yes or No

Any dizziness? Yes or No Fainting? Yes or No Joint Stiffness? Yes or No Gout? Yes or No

PAST SURGERIES AND YEAR PERFORMED:_____

_____

_____

ALLERGIES: (Please also indicate what type of reaction)_____

_____

MEDICATIONS: (Please indicate Name of drug, dosage and how often taken)

_____

_____

_____

_____

_____

SOCIAL HISTORY: (Please Circle) Y N---- Smoke Packs per day:_____ How many years?_____

Y N---- Alcohol Drinks per day:_____ Y N---- Illegal Drugs

Year of last Tetanus vaccination:_____

FAMILY HISTORY:

Please list all illnesses/diseases of family members. Also list their status: Alive or Deceased (If so what age)

Mother:_____

Father:_____

Brothers:_____

Sisters:_____

Grandparents:_____

_____

PAST MEDICAL HISTORY

Circle Y for Yes or N for No

Cardiovascular:

Y N----Angina
Y N----Heart Disease
Y N----Congestive Heart Failure
Y N----Blood Clots
Y N----Blood Pressure
High or Low
Y N----Swelling in Ankles
Y N----Stroke
Y N----Varicose Veins
Y N----Murmur
Y N----Irregular Heartbeat

Childhood Illnesses:

Y N----Anything unusual

Dermatologic:

Y N----Skin Problems

Endocrine:

Y N----Diabetes (Type:_____)

Hemoglobin A1C___%Date_____

Y N----Thyroid Problems
Y N----Weight Changes > 10 lbs.

G.I.:

Y N----Gall Bladder Problems
Y N----Stomach Ulcers
Y N----Liver Problems
Y N----Bowel Problems
Y N----Bloody Stools

G.U.:

Y N----Kidney Problems
Y N----Kidney Stones
Y N----Prostate Cancer
Y N----Cancer/Tumors

H.E.E.N.T.:

Y N----Dentures
Y N----Eye Problems
Y N----Hearing Problems
Y N----Nose Problems
Y N----Throat Problems

Hematologic:

Y N----Anemias
Y N----Bleeding Tendencies
Y N----High Cholesterol
Y N----High Triglycerides

Immunologic:

Y N----Infection Fighting Problems

Musculoskeletal:

Y N----Arthritis
Y N----Joint Replacements
Y N----Osteoporosis
Y N----Tumors

Neurologic:

Y N----Fainting
Y N----Seizures
Y N----Stroke
Y N----Pinched Nerve

Psychiatric:

Y N----Depression
Y N----Psychiatric

Respiratory:

Y N----Asthma
Y N----Bronchitis
Y N----Shortness of Breath
Y N----Sleep Apnea

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OUR FINANCIAL POLICY

Thank you for choosing us as your podiatry provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our Financial Policy which we require you read and sign prior to any treatment. All patients must complete our information and insurance form before seeing the doctor.

REGARDING INSURANCE BILLING

FOR OUR MEDICARE PATIENTS, WE WILL FILE YOUR CLAIM. HOWEVER, YOU MIGHT RECEIVE SERVICES THAT AREN'T COVERED BY MEDICARE AND THOSE SERVICES WILL NEED TO BE PAID AT THAT TIME. Regarding Insurance Plans where we are a participating provider, we will file your claim first. **ALL CO-PAYS ARE DUE AT THE TIME OF SERVICE.** In the event that your insurance coverage changes to a plan where we are not a participating provider, refer to the paragraph below._____**(Initial Please)**

Insurance Plans where we are a non-participating provider, we may accept assignment of insurance benefits after your initial visit. However, we do require 50% of the bill be paid at time of service. The balance is your responsibility whether your insurance company pays or not. We cannot bill your insurance company unless you give us your insurance information. Your insurance policy is a contract between you and your insurance company. We are not a party to that contract.

REGARDING NO INSURANCE BILLING

WE REQUIRE PAYMENT AT TIME OF SERVICE. HOWEVER IF A PAYMENT ARRANGEMENT IS NEEDED WE WILL NEED AN AGREEMENT UP FRONT PRIOR TO SERVICES BEING RENDERED. THE FOLLOWING WILL APPLY.

I AGREE TO PAY $_____ EVERY_____ TILL PAID IN FULL.

USUAL AND CUSTOMARY RATES

Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary._____**(Initial Please)**

Thank You for understanding our Financial Policy. Please let us know if you have questions or concerns. I have read the Financial Policy. I understand and agree to this Financial Policy. I authorize the release of medical information necessary to process any claim, and authorize supplemental insurance to pay benefits directly to provider.

Interest will be applied to any unpaid balance at the note of 1 ½% per month, 18% annum.

There is a fee of $25 due at time of service for physician to fill out work/disability/FMLA paper work.

X_____ **DATE:**_____
Signature of Patient or Responsible Party

X_____ **DATE:**_____
Signature of Co-Responsible Party

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HIPAA: AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

PATIENT INFORMATION:

Name:_____ **DOB:**_____

Address:_____

Phone:_____

Mother's Maiden Name: _____

I AUTHORIZE INDIANA FOOT & ANKLE TO DISCLOSE OR PROVIDE PROTECTED HEALTH INFORMATION ABOUT ME, TO DISCUSS ANY TEST RESULTS, MEDICAL FINDINGS, AND ANY FINANCIAL INFORMATION WITH THE FOLLOWING PEOPLE:

AUTHORIZED PERSON: _____ RELATIONSHIP: ____
Phone:_____
AUTHORIZED PERSON: _____ RELATIONSHIP: ____
Phone:_____
AUTHORIZED PERSON: _____ RELATIONSHIP: ____
Phone:_____

RELATIONSHIP CODES: S=SPOUSE, C=CHILD, P=PARENT, O=OTHER

THIS AUTHORIZATION WILL EXPIRE ONE YEAR FROM THE DATE AT THE BOTTOM OF THIS FORM. YOU HAVE THE RIGHT TO TERMINATE THIS AUTHORIZATION AT ANY TIME BY CONTACTING OUR OFFICE IN WRITING.

WE HAVE NO CONTROL OVER THE PERSON(S) YOU HAVE LISTED TO RECEIVE YOUR PROTECTED HEALTH INFORMATION. THEREFORE, YOUR PROTECTED HEALTH INFORMATION DISCLOSED UNDER THIS AUTHORIZATION WILL NO LONGER BE PROTECTED BY THE REQUIREMENTS OF THE PRIVACY RULE AND WILL NO LONGER BE THE RESPONSIBILITY OF INDIANA FOOT & ANKLE.

I HAVE RECEIVED A COPY OF INDIANA FOOT & ANKLE PRIVACY POLICY.

SIGNATURE OF PATIENT, OR GUARDIAN IF PATIENT IS UNDER THE AGE OF 18 YEARS AND NOT EMANCIPATED OR POWER OF ATTORNEY:

_____ DATE: _____