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JASPER — 645 W. 5th St. • Jasper, IN 47546 • 812-634-2778 • Fax: 812-634-2909  
NEWBURGH — 7580 Peachwood Dr. • Newburgh, IN 47630 • 812-858-3800 • Fax: 812-858-3810

**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: \_\_\_\_\_)
- 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 \_\_\_\_\_  
Signature of Patient or Responsible Party

DATE: \_\_\_\_\_

X \_\_\_\_\_  
Signature of Co-Responsible Party

DATE: \_\_\_\_\_



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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: \_\_\_\_\_