SIMMONS
FOOT AND ANKLE

Please bring the following to your appointment:

- Insurance card
- Photo identification
- Medication list

Patient Information

Name _____ Patient's Social Security number _____

Sex: ☐ Male ☐ Female

Race: ☐ White or Caucasian ☐ Black or African American ☐ Native American ☐ Asian ☐ Hispanic or Latino

Date of birth _____ Age _____

How did you hear about our office?

☐ Physician referral: which physician office? _____
☐ Friend or family member
☐ Insurance
☐ Internet: which website or search engine? _____

Home address _____
City _____ State _____ Zip code _____

Home phone _____ Cell phone _____

Email _____

Who is guarantor of your insurance? ☐ Myself ☐ Parent or Spouse (their name) _____

Guarantor's date of birth _____

Preferred pharmacy _____ Crossroads _____

Primary care physician _____ Date of last visit _____

Height: ____ Feet ____ Inches Weight: ____ lbs. Shoe Size _____

Reason for today's visit _____

How long have you had these symptoms? _____

Have you treated the pain in any way?

☐ Medication _____
☐ Changed shoe type or size
☐ Stretching
☐ Other _____

How would you describe the pain?

☐ Deep aching
☐ Sharp, shooting pain
☐ Numbness/ Burning
☐ Other _____

Have you seen anyone prior to this appointment? ☐ Yes ☐ No

Have you had any prior foot surgery? ☐ Yes ☐ No
If yes, please list the name of the procedure and date it occurred.

_____

_____

_____

Patient Information (continued)

Medical History

Are you pregnant? ☐ Yes ☐ No
Are you nursing? ☐ Yes ☐ No

Do you smoke?
☐ Never ☐ Everyday (#packs/day _____)
☐ Some days ☐ Quit

How long ago did you quit? _____

Have you had any of the following? Check only if your answer is yes.

☐ Anemia
☐ Angina or chest pain
☐ Arthritis
☐ Asthma
☐ AIDS/HIV
☐ Blood clots (DVT)
☐ Cancer (type)_____
☐ Chronic obstructive pulmonary disease (COPD)
☐ Congestive Heart Failure (CHF)
☐ Coronary artery disease
☐ Depression
☐ Diabetes
☐ Drug or alcohol abuse
☐ Gastric ulcer
☐ Gout
☐ Heart attack
☐ High cholesterol
☐ Hypertension
☐ Kidney disease
☐ Lower back pain
☐ Liver diease (e.g. chirrosis, hepatitis....)
☐ Lymphedema
☐ Metal implants/pacemaker
☐ Neuropathy
☐ Peripheral arterial disease
☐ Sciatica
☐ Sleep apnea Osteoporosis
☐ Stroke (TIA)
☐ Thyroid disease

Allergies

Are you allergic to any of the following?

☐ None; I have no known allergies
☐ Adhesives or tape
☐ Latex
☐ Aspirin
☐ Penicillin
☐ Local anesthetics
☐ Iodine dye
☐ Sulfa drugs, (for example, Bactrim)
☐ Seafood
☐ Morphine
☐ NSAIDs (Motrin, Alleve, Naprosyn, Ibuprofen)
☐ Codeine
☐ other _____

Medication List

Please list all medication you are currently taking

☐ Check here if you have attached a list

_____
_____
_____
_____
_____
_____
_____
_____
_____

Family History

Do you have a family history of any of the following?

☐ Stroke
☐ Heart disease or heart attack
☐ Cancer
☐ Diabetes

SIMMONS
FOOT AND ANKLE

Authorization and Consent

Financial Responsibility

I am aware that benefits are determined by my insurance company and not by the provider. Verification of benefits is not a guarantee of payment, and I will be responsible for any portion of my treatment that is not covered or is denied by the insurance company including my co-payments, deductibles, and co-insurance. I understand that all co-pays and service charges that are not covered by my insurance company will be due at the time of service. I understand the provider is not responsible for the misquotation of benefits from my insurance company. Insurance benefits are determined by my insurance company when the claim is received. I hereby authorize Simmons Foot and Ankle to release any information, for insurance purposes, required in the course of my examination or treatment. I hereby authorize payment directly to Simmons Foot and Ankle for treatment, if any, otherwise payable to me for services. I understand that I am responsible for all charges if it is determined that the insurance information that I have provided is incorrect. I understand that there will be a $20.00 service charge on all returned checks.

HIPAA / Records Authorization

I, the undersigned understand I have a right to review, if I choose to, Simmons Foot and Ankle, Notice of Privacy Practices prior to signing this document, which are available upon request or on our website, www.SimmonsFootandAnkle.com. The privacy of your medical records and personal information is important to us. Documentation of your medical treatment and services rendered are created to provide you with quality care and to comply with certain legal requirements (HIPAA guidelines). Our legal duty is to keep your medical information private and to comply with the terms and conditions of the current notice. We may disclose information for treatment, payment, or to healthcare personnel for the purpose of the quality of your care, and to obtain any authorizations, pre-certifications, etc. I further understand that any person(s) that receive these medical records will not release any of the medical information obtained by this authorization to any other person or organization without a further authorization signed by me for release of the information. Any information you do not wish to disclose must be specified in writing. Any information being requested to be released to anyone besides a referring or treating physician must be submitted to us in writing.

Consent for Treatment

I have read and understand the statements above. I give my permission to the doctor(s) of Simmons Foot and Ankle to administer and perform procedures as may be deemed necessary to the diagnosis and/or treatment of me or my dependents' condition. As a representative of myself or as a guardian, I give authorization for the above listed patient to receive medical and/or surgical care and treatment at Simmons Foot and Ankle.

Printed patient's name _____

Patient's signature _____ *Date* _____

or

Parent's/Guardian's signature _____ *Date* _____