ADVANCED CARE FOOT & ANKLE

930 Folly Road
Suite D
Charelston SC, 29412

Phone: (843) 606-0019
Fax: (843) 604-0566
charlestonpodiatrist.com

PATIENT INFORMATION SHEET

Last Name: _____ First Name (Legal): _____MI: _____

Email: _____ Preferred Name: _____

Sex: □ Male □ Female Marital Status: □ Single □ Married □ Divorced □ Widowed Birth Date: _____ Age: _____

Emergency Contact: _____Phone: (_____) _____Relationship: _____

Pharmacy Name/Town:_____ Pharmacy Phone (_____) _____

Primary Care Physician/Town:_____ Occupation:_____

How did you find us? □ Online □ Friend □ Doctor Referral □ Mailer □ Hospital □ Seminar □ Insurance □ Sign/Building

Who can we thank for your referral?_____

Street/Apt: _____City: _____State:_____Zip_____

Home Phone: (_____) _____ Cell Phone: (_____) _____ □ Patient Cell □ Parent Cell □ Caregiver

INSURANCE INFORMATION:

Primary Insurance: _____ ID#_____

Insurance Holder Name / Date of Birth (if different than patient) _____

Secondary Insurance: _____ID#_____

MEDICAL HISTORY: Weight _____ lbs Height _____ Shoe Size: _____

Describe Foot/Ankle Problem: □ Right □ Left _____

_____

Ever Been to a Foot Doctor Before? □ Yes □ No For What? _____

Do you have, or have you ever been treated for:

- ☐ GERD
- ☐ Stomach Ulcer
- ☐ Liver Disease
- ☐ Hepatitis
- ☐ AIDS/HIV
- ☐ Hypothyroid
- ☐ Hyperthyroid
- ☐ Diabetes
- ☐ Heart Attack
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Arrhythmia
- ☐ Valvular Heart Dz
- ☐ Asthma
- ☐ Lung Disease
- ☐ Rheumatoid Athritis
- ☐ Arthritis
- ☐ Osteoprosis
- ☐ Gout
- ☐ Poor Circulation
- ☐ Kidney Disease
- ☐ Anemia
- ☐ Psychiatric Disorder
- ☐ Alzheimers
- ☐ Epilepsy
- ☐ Fibromyalgia/RSD
- ☐ Stroke
- ☐ Hearing/Ear Disorder
- ☐ Glaucoma
- ☐ Nerve Disorder
- ☐ Sciatica
- ☐ Cancer

Other Past Medical History Not Listed: _____

_____

Past Surgical History: _____

_____

Allergies to Medications: _____

Current Medications (doses not necessary): _____

_____

_____

Family History: □ Diabetes □ Heart Disease □ Poor Circulation □ Blood Clots □ Stroke □ Foot Problems □ Melanoma

Social History: Smoking Status: □ Former □ Current □ Never Alcohol Consumption: □ Daily □ Occasionally □ Never

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CONSENT FOR EVALUATION/TREATMENT and HIPAA ACKNOWLEDGEMENT

Initials: _____ I consent to evaluation and in-office treatment at this office or any satellite office under common ownership. I consent that the physician performs a medical examination, and reasonable and necessary testing and in-office treatment for the condition which has led me to seek care at this practice

Initials: _____ You have the right to be informed about your condition, including recommended diagnostic tests, medical or surgical treatments, and the benefits and risks of any options. At this time, no specific treatments have been recommended. This consent is to authorize evaluation and in-office treatments or procedures as needed to identify and address any condition.

Initials: _____ I understand that my health history can and will be used to: Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in my treatment directly and indirectly. I understand that my health history can and will be used to: Obtain payment from third-party payers. I understand that my health history can and will be used to: Conduct normal healthcare operations such as quality assessments and physician certifications.

Initials: _____ You acknowledge receipt of the Notice of Privacy Practices, which provides further details on the use and disclosure of your health information, and can request a copy at any time.

OFFICE FINACIAL POLICY AND NO SHOW/CANCELLATION POLICY

Initials: _____ Our office values punctuality and strives to see patients on time without overbooking. To maintain this standard, it is essential that patients arrive promptly for their appointments. Therefore, a $25 "No-Show/Late Cancellation" fee will be charged to patients who miss their appointment without notifying the office at least 12 hours in advance. This fee must be paid before scheduling future appointments. I acknowledge and accept this policy.

Initials: _____ If your insurance plan requires a copay, it is due at the time of your visit. For patients whose insurance plans include high deductibles or coinsurance, a pre-payment toward your remaining deductible will be required at the time of service. This allows us to process your claim more efficiently and reduce the risk of unexpected balances later. I acknowledge and accept this policy.

Initials: _____ Please note that a 2.6% processing fee will be added to all payments made by credit or debit card. This fee is collected by our office, but is passed directly to the credit card companies to cover our transaction costs. We accept cash or check for those wishing to avoid additional charges. I acknowledge and accept this policy.

Initials: _____I understand that I am fully responsible for my bill if denied by my insurance company. I understand that I am fully responsible for obtaining any referrals required by my insurance company and being aware that all referrals are made out appropriately to my doctor

SIGNATURE ON FILE

I certify that I have read and fully understand the above (8) statements, and consent fully and voluntarily to its contents

Patient Name: _____ Signature: _____ Date: _____
(if minor parent/guardian signs on their behalf)