NEW PATIENT DEMOGRAPHIC and MEDICAL FORM

Established patients must complete the UPDATE Form – Not This Form

Patients First & Last Name_____ DOB_____ Sex_____

SSN_____ Language Other Than English _____

Race_____ Hispanic/Latino ❑ YES ❑ NO Marital Status: ❑Married ❑Single ❑Divorced ❑Widow

Mailing Address_____

City_____ State_____ Zip_____

Home Phone_____ Cell Phone_____ Work Phone_____

I authorize Associated Foot Surgeons, it's representative, physicians and staff to leave messages related to my healthcare and appointment reminders via ❑ Home Phone ❑ Cell Phone ❑ Work Phone ❑ Email _____

EMERGENCY CONTACT_____ Phone_____ Relationship_____

Primary Insurance Carrier_____

Group Number_____ ID Number_____

Policy Holders Name _____ SSN_____ DOB_____

Secondary Insurance Carrier_____

Group Number_____ ID Number_____

Policy Holders Name _____ SSN_____ DOB_____

Person Responsible for The Bill _____

SSN_____ DOB _____ Phone Number_____

Mailing Address_____

City_____ State_____ Zip_____

Height _____ **Weight** _____ **Shoe Size** _____

Past Surgical History (include dates)

_____

_____

Reason for visit _____ ❑ Right ❑ Left ❑ Both

How long? ____Days ____Weeks ____Months ____Years

Injury? ❑ YES ❑ NO When _____ Where_____

Is this a Workman's Compensation claims? YES ❑ NO ❑ Claim #_____

Contact Person_____ Phone Number_____

Primary Care Physician_____ Date Last Seen_____

Date of Flu Vaccine_____ Date of Pneumonia Vaccine_____

Phone Number_____ Fax Number_____

Address_____

City_____ State_____ Zip_____

Specialist Name_____ Phone Number_____

❑ Cardiologist ❑ Internal Medicine ❑ Endocrinologist ❑ Neurologist ❑ Oncologist

PHARMACY ❑ CVS ❑Medco ❑Schnucks ❑Target ❑Walgreens ❑Wal-Mart ❑Other

Address_____ Phone_____

MEDICAL HISTORY

1	Acid Reflux	11	Anemia	21	Arthritis	31	Angina	41	Abnormal Bleeding
2	Artificial Joint(s)	12	Asthma/Bronchitis	22	Bladder Infections	32	Back Trouble	42	Blood Clots
3	Blood Transfusion	13	Cancer	23	Cancer of Skin	33	Diabetic: Type 1 or 2	43	Epilepsy
4	Fibromyalgia	14	GERD	24	GOUT	34	Heart/Disease/Failure	44	High Blood Pressure
5	Kidney Stones	15	Leg/Feet Cramps	25	Liver Disease	35	Low Blood Pressure	45	Lung Disease
6	Neuropathy	16	Open Sores	26	Phlebitis	36	Psychiatric Disorder	46	Peripheral Vascular Disease
7	Pneumonia	17	Respiratory Disease	27	Rheumatoid Arthritis	37	Radiation Therapy	47	Restless Leg Syndrome
8	Rheumatic Fever	18	Skin Disorder	28	Sleep Apnea	38	Sickle Cell Disease	28	Skin Disorder
9	Stroke	19	Steroid Treatment	29	Thyroid Disease	39	Varicose Veins	49	Tuberculosis
10	Hepatitis	20	MRSA Infection	30	HIV+/AIDS	40	Other	50	Family Member Deceased

FAMILY HISTORY

Do you have a family history of the above listed items? If so, indicate who with the corresponding number

Mother_____ Father_____ Sister_____ Brother_____

Allergic or Sensitive to: ❑ Tape ❑ Latex ❑ Shellfish ❑ Iodine ❑ Other_____

❑ Medications_____ ❑ Anesthesia_____ ❑ No Known Allergies

Any problems with local anesthetic (Novocaine, Lidocaine) ❑ Yes ❑ No If yes, describe

_____

Have you had any problems taking aspirin or ibuprofen (Advil, Motrin, etc) ❑ YES ❑ NO

Medications you are taking ❑ See List ❑ Not currently taking medications

_____

_____

Diabetes ❑ YES ❑ NO How long_____ Insulin ❑ YES ❑ NO

History of smoking or tobacco use ❑ YES ❑ NO If yes, how much per day_____

If no, have you smoked or used tobacco in the past ❑ YES ❑ NO Years_____ Year Quit_____

History of drinking alcohol/beer ❑ YES ❑ NO ❑ If yes, 1-2 per week ❑ 1-2 per day ❑ More than 2 daily

ACKNOWLEDGEMENT AND CERTIFICATION OF INFORMATION

ASSIGNMENT OF BENEFITS TO PHYSICIAN/INSURANCE COMPANIES: ☐ YES ☐ NO (If NO, then you agree to selfpay)

I hereby authorize payment directly to the physician for surgical and/or medical benefits. I also understand I am responsible for any portion of my bill not covered by my insurance company. Additionally, I authorize release of information for Insurance claim purposes.

RECEIPT OF "Notice of Privacy Practices":

We are required by law to maintain the privacy of and provide individuals with this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to the information provided, please ask to speak to our HIPAA Compliance Officer in person or by phone at our main phone number. (618-277-5700)

- **This is to acknowledge that you have received the Notice of our Privacy Practices.**
- **This also certifies that the insurance information you provided is current and accurate.**
- **You are personally responsible for any balances due if you provide wrong insurance information.**
- **If your insurance company requires a referral, and you do not have one, you are responsible for any charges incurred.**
- **If you do not pay your bill within 30 days you will be charged an $8.00 rebilling fee each month. If not paid after 60 days, your account may be sent to collections. You will be responsible for any additional fees incurred.**
- **I understand all of the information on this form and herby state that the information I have provided is correct to the best of my knowledge.**

I authorize Associated Foot Surgeons to release information to:

Name_____ Relationship _____ Phone_____ Medical❑ Financial❑

Name_____ Relationship _____ Phone_____ Medical❑ Financial❑

_____ _____ _____

Form Completed By – Print Name Signature Date

Relationship to Patient ❑ Self ❑ Father ❑ Mother ❑ Legal Guardian ❑ Other:_____