Amelia Island Foot and Ankle
1325 Atlantic Ave
Fernandina Beach, FL 32034
Phone: 904-261-3653 Fax: 904-261-7790

Patient Demographics

Legal Name: _____
Last First Middle

Address: _____
Street City State Zip

Seasonal Address: _____
Street City State Zip

Dates at Seasonal Address: _____thru_____ Preferred Way of Contact: Home __ Work __ Cell __

Phone: Home ( )_____ Work ( )_____ Cell ( )_____

Email:_____ I Authorize Email Contact: Yes ____ No____

Date of Birth: _____ Age: _____ Social Security #:_____ Sex: Male___ Female ___

Marital Status: Married __ Single__ Separated __ Other__ Language: _____

Employed: Yes___ No___ Employer: _____ Occupation: _____

Emergency Contact: _____ Phone: _____
Name/Relation

Primary Care Physician: _____ Phone: _____

Race: White__ Black __ Hispanic __ Asian __ American Indian __ Other: _____

Ethnicity: African American __ American __ American Indian __ Hispanic __ Italian __ Other: _____

The above information pertains to the patient only. If the patient is a minor or under the supervision of a legal guardian, then the responsible party must complete the following section. If this does not apply, then you may skip to the next section.

Guardian Information/Primary Insured Information

Name: _____
Last First Middle

Address: _____
Street City State Zip

Phone: Home ( ) _____ Work ( ) _____ Cell ( ) _____

Date of Birth: _____ Age: _____ Social Security #:_____ Sex: Male___ Female ___

Employed: Yes___ No___ Employer: _____ Occupation: _____

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Please fill out this form as completely as possible. It will assist the doctor in developing a plan of care for you. If you have any questions please feel free to ask for assistance. This information is confidential.

Medical History:

Chief Complaint:

_____

_____

When did your symptoms first appear or accident occur (date):

_____

_____

Please describe your pain/discomfort: Burning __ Numbness __ Sharp __ Other _____

What makes your pain/discomfort better? _____

What makes your pain/discomfort worse? _____

Has this condition been previously treated? Yes __ No __
If yes please tell us how and when:

_____

_____

Have you had prior surgery anywhere on your body? Yes __ No __
If yes please list type and date of surgery:

_____

_____

_____

_____

_____

Height: _____ Weight: _____ Shoe size: _____

Our Office grows mainly by referral from other patients. Whom may we thank for referring you to our office?

_____

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Are you being treated for or have been treated for any of the following?

Alcoholism	Yes__	No__	Heart Attack	Yes__	No__
Anemia	Yes__	No__	Hepatitis or Jaundice	Yes__	No__
Arthritis	Yes__	No__	High Blood Pressure	Yes__	No__
Asthma	Yes__	No__	HIV/AIDS	Yes__	No__
Bronchitis or Emphysema	Yes__	No__	Kidney Trouble	Yes__	No__
Cancer or Tumor	Yes__	No__	Mitral Valve Prolapse	Yes__	No__
Cholesterol/Triglycerides	Yes__	No__	Rheumatic Fever	Yes__	No__
Diabetes	Yes__	No__	Stomach Ulcers	Yes__	No__
Last Blood Sugar #/A1C_____ How Long? _____			Stroke	Yes__	No__
Drug Abuse	Yes__	No__	Thrombophlebitis	Yes__	No__
Epilepsy or Seizure	Yes__	No__	Thyroid Disease	Yes__	No__
Gout	Yes__	No__	Tuberculosis	Yes__	No__

Are you **ALLERGIC** to or have you ever reacted to any of the following?

Antibiotics/Penicillin	Yes__	No__	General Anesthesia	Yes__	No__
Aspirin	Yes__	No__	Latex	Yes__	No__
Band Aids/Tape	Yes__	No__	Radiographic Contrast/Dye	Yes__	No__
Codeine	Yes__	No__	Sedative	Yes__	No__
Iodine	Yes__	No__	Sulfa Drugs	Yes__	No__
Lidocaine/Novacaine (Local Anesthesia)	Yes__	No__	Other not listed? _____		

Social History

Have you ever used Tobacco? Yes __ No __ If yes, how many packs per day and how long? _____
Do you use Recreational Drugs? Yes __ No __ Do you exercise on a regular basis? Yes __ No __
Are you pregnant? Yes __ No__ If yes delivery date? _____ Are you nursing? Yes __ No__
Do you drink Alcohol? Yes __ No__ How Many?_____
Do you drink Caffeine? Yes __ No __

Family History

Please list your relationship to the family member who has had the following problems:

Bleeding Disorders	Yes__	No__	_____	Kidney Disease	Yes__	No__	_____
Cancer	Yes__	No__	_____	Mental Illness	Yes__	No__	_____
Diabetes	Yes__	No__	_____	Rheumatology	Yes__	No__	_____
Heart Disease	Yes__	No__	_____	Stroke	Yes__	No__	_____
High Blood Pressure	Yes__	No__	_____	Other	Yes__	No__	_____

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Review of Systems

Please place a check next to the following problems that affect you.

Cardiovascular:

____Calf Pain with exercise/while sleeping
____Congestive heart failure
____Chest pain/heart attack
____Heart Failure
____Palpitations
____None of the above

Integumentary (Skin):

____Birthmarks
____Growth on skin
____Piercing
____Recurrent infections
____Skin Ulcers/Wounds in the past
____Changes in Skin Color
____None of the above
____Hair Loss
____Rash
____Sensitivity to sunlight
____Eczema
____Lesions
____ Tattoos

Musculoskeletal:

____Bursitis
____Prior Fractures/Sprains
____Joint Pain/Swelling/Stiffness
____Tendonitis
____Weakness of Limbs
____None of the above

Neurological:

____Confusion
____Nervous Disorders
____Speech Difficulties
____Fainting
____None of the above
____Migraines
____Poor Balance
____Neuropathy (loss of sensation
____Insomnia

Psychiatric:

____Depression ____Nervousness ____Tension ____None of the above

Respiratory:

____Cough ____Wheezing ____Difficulty breathing ____Shortness of Breath ____None of the above

To the best of my knowledge, the questions above were accurately answered. I understand that providing inaccurate information can be dangerous to my health.

_____ _____ _____

Patient's Name (please print) **Patient's Signature** **Date**

_____ _____

Physician's Signature **Date**

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Pharmacy Information

Pharmacy Name: _____ Phone: _____

Address:_____

Do you take medication on a daily basis, including pills, injectables, or herbs? Yes ___ No ___

Medication	Dosage
1.	
2.	
3.	
4.	
5.	
6.	
7.	
8.	
9.	
10.	
11.	
12.	
13.	
14.	
15.	
16.	
17.	
18.	
19.	
20.	

I authorize Amelia Island Foot and Ankle Association to download my medication history and Rx benefits into my account from an Rx clearinghouse.

_____ _____

Patient Signature Date

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Appointments

If you are unable to keep an appointment please call the office to reschedule at least 24 hours in advance. Patients with three missed appointments may be asked to transfer their records to another doctor. Patients who are more than 15 minutes late may be asked to reschedule.

Leaving Messages

Our office policy is to leave generic, harmless information on answering machines. We would like to accommodate our patients and can do so by initialing next to your preference.

1. _____ leave very little information.
2. _____ please call # _____ and leave specific details.
3. _____ please leave as much information as possible on the machine or with anyone who answers my phone.

Financial Policy

This is an agreement between Amelia Island Foot and Ankle Association, a Florida corporation, as creditor and the patient/debtor named on this form. In this agreement the words "you", "your", and "yours" means the patient/debtor. The word "account" means the account that has been established in your name to which charges are made and payments credited. The words "we", "us", and "our" refer to the Amelia Island Foot and Ankle Association. By executing this agreement you are agreeing to pay for all services rendered.

Insurance

Insurance is a contract between you and your insurance company. (We are not a party to this contract, in most cases). We will bill your primary insurance company only if we are a contracted participating provider. We will accept secondary insurances for Medicare. Although we may estimate what your insurance company may pay, it is the insurance company that makes the final determination of your eligibility. You agree to pay any portion of the charges not covered by insurance. We may assist you, at our discretion, in verifying your insurance coverage in an effort to verify exactly what podiatric coverage is available on your policy. This can only be done on the day of your appointment if time permits. You as the policyholder are primarily responsible to verify benefits. We cannot guarantee payment of the benefits and subsequently you may be responsible for any coinsurance, deductibles, or fees for non-covered services that may result.

Referrals

If your insurance company requires a referral and/or preauthorization/pre-certification you are responsible for obtaining it. We most likely will not be able to obtain a referral on the date of service, (and this will be at our discretion if time permits). Options at this point will be to reschedule the appointment or to pay at the time of service. We suggest you call your primary doctor at least 24 hours in advance to confirm that your referral has been generated and faxed. The most reliable method is to obtain it yourself.

Required Payments

Any co-payment, deductibles or coinsurances, fees for non-covered services, or outstanding balances must be paid at the time of service. **Payment Options:** You may choose to pay cash, check, or credit card on the day that the treatment is rendered. Returned Checks There is a fee (currently $25) for any checks returned by the bank.

Monthly Statement

If you have a balance on your account, we will send you a monthly statement. It will show separately the balance, any new charges to the account, and the finance charge, if any.

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Payments

Unless other arrangements are approved by us in writing, the balance on your statement is due and payable when the statement is issued, and is past due if not paid by the end of the month.

Past Due Accounts

If your account becomes past due, we will take the necessary steps to collect this debt. If we have to refer your account to a collection agency you agree to pay all of the collection of the balance to a lawyer, you agree to pay all the lawyer's fees which we incur, plus all court costs. In case of suit, you agree the venue shall be in Nassau County, Florida.

Waiver of Confidentiality

You understand if this account is submitted to an attorney or collection agency, if we have to litigate in court, or if your past due status is reported to a credit reporting agency, the fact that you received treatment at our office may become a matter of public record.

Effective Date

Once you have signed this document you agree to all of the terms and conditions contained herein and the agreement will be in full force and effect.

_____ _____

Patient's Signature Date

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the NOTICE OF PRIVACY PRACTICES by the Amelia Island Foot and Ankle Associates and that I have read (or had the opportunity to read if I so chose) and understood the notice.

_____ _____

Patient's Signature Date

I GIVE AUTHORIZATION TO DISCUSS MY PROTECTED HEALTH INFORMATION TO THE FOLLOWING:

Please provide us with the names and relationships who you would like us to share your information with.

MEDICAL INFORMATION RELEASE

I authorize the release of medical information to my insurance company necessary to process my claim. I also authorize the payment of medical benefits directly to my physician. I understand I am financially responsible for charges not covered by this authorization.

_____ _____

Patient's Signature Date