

Welcome to our Office

Last Name _____ First _____ MI _____ SS# _____

Birth Date _____ Sex _____ Age _____

Marital Status (circle one) S D M W Spouses Name _____

Permanent Address _____ City _____ State _____ Zip _____

Local Phone _____ Work Phone _____ Cell Phone _____

Email address _____ Other Phone _____

Other address _____ City _____ State _____ Zip _____

Employer _____ Occupation _____

Employer Address _____ City _____ State _____ Zip _____

Family Physician _____ Phone _____

Physician Address _____ City _____ State _____ Zip _____

Chief Complaint _____

Who may we thank for referring you to this office? _____

Their address _____

Personally legally responsible for this account _____

Birth date _____ Sex _____ Relationship to patient _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Work Phone _____

Please give the receptionist your insurance cards if you are not paying for your visit today.

I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment.

Signature of patient (If minor, signature of parent/guardian) _____

Date _____

Gulfcoast Foot and Ankle Center, Inc.

9955 Tamiami Trail North,
Suite 1, Naples, FL 34108
(239) 566-8800 Fax (239) 566-8778

Physicians Regional Medical Center
6101 Pine Ridge Road, 3rd Floor
Naples, FL 34119
(239) 304-5161 Fax (239) 304-5193

3501 Health Center Blvd, #2150,
Bonita Springs, FL 34135
(239) 949-3399 Fax (239) 949-6553

MEDICAL INFORMATION GENERAL

Have you seen another doctor for your foot problems? Yes No

Was the doctor a podiatrist? Yes No Have you ever worn orthotics? Yes No

Name and telephone number of previous doctor(s) who treated your foot problem(s)

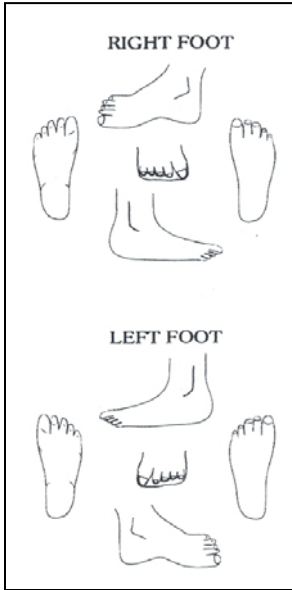
What is your foot problem? _____

How long have you been bothered by this problem? _____

What have you done for your foot problem(s)? _____

On the diagram below, please mark the place(s) where you are experiencing pain in your feet:

Regarding the place(s) you marked above, describe the pain you experience, for instance, mild, moderate, severe, throbbing, burning, etc., and the time of day it occurs



FAMILY MEDICAL HISTORY

Mother	<input type="checkbox"/> Living	<input type="checkbox"/> Deceased _____(age)	Cause of Death _____
Father	<input type="checkbox"/> Living	<input type="checkbox"/> Deceased _____(age)	Cause of Death _____
Brother	<input type="checkbox"/> Living	<input type="checkbox"/> Deceased _____(age)	Cause of Death _____
Sister	<input type="checkbox"/> Living	<input type="checkbox"/> Deceased _____(age)	Cause of Death _____

Has anyone in your family ever been treated for:

	You	Father	Mother	Brother	Sister	Children	Relative
Bleeding disorder							
Cancer							
Diabetes							
Foot problems							
Heart Disease							
Neuromuscular disease							
Peripheral vascular disease							
Strokes							

Gulfcoast Foot and Ankle Center, Inc.

9955 Tamiami Trail North,
Suite 1, Naples, FL. 34108
(239) 566-8800 Fax (239) 566-8778

Physicians Regional Medical Center
6101 Pine Ridge Road, 3rd Floor
Naples, FL 34119
(239) 304-5161 Fax (239) 304-5193

3501 Health Center Blvd, #2150,
Bonita Springs, FL 34135
(239) 949-3399 Fax (239) 949-6553

MEDICAL HISTORY

Height _____ Weight _____ Date of last physical exam: _____ Shoe Size R _____ L _____
 Do you smoke? Yes No # of packs per day _____
 Previously smoked? Yes No # of years smoked _____
 Do you drink? Yes No If yes, how often? 1-2 per week 1-2 per day more than 2 daily

WOMEN: Number of Children _____ Are you pregnant? Yes No # of month's pregnant _____

Diabetes/Circulation

Are you under active care for Diabetes and or circulation problems? Yes No

If so, Doctors name _____ Telephone Number _____ Date Last Seen _____
 Insulin dependent Diabetic? Yes No Diet Controlled? Yes No

of years being diabetic _____ Average blood sugar range _____ How often do you check? _____

Allergies:

- Any Antibiotic Aspirin Codeine Cortisone Food allergies
- Grass, mold, dust Hay fever Local anesthesia Mercurials Novocaine
- Penicillin Sulfa drugs Tape Other _____
- No Known Allergies**

Pharmacy: What pharmacy do you use? _____ Phone _____

Medications: Please list any and all medications now being taken (with dosage).

Name of Medication	Reason for Taking it	How Often Do You Take It?

Have you taken Prednisone over the past 6 months? Yes No

Surgeries and Hospitalizations: List previous surgeries and hospitalizations, dates and reasons.

Previous Surgeries/Hospitalizations	Approximate Dates	Reason

Gulfcoast Foot and Ankle Center, Inc.

9955 Tamiami Trail North,
 Suite 1, Naples, FL 34108
 (239) 566-8800 Fax (239) 566-8778

Physicians Regional Medical Center
 6101 Pine Ridge Road, 3rd Floor
 Naples, FL 34119
 (239) 304-5161 Fax (239) 304-5193

3501 Health Center Blvd, #2150,
 Bonita Springs, FL 34135
 (239) 949-3399 Fax (239) 949-6553

MEDICAL HISTORY

Review of systems (ROS)

Please check each item that applies to you.

Constitutional (general):

- Weight loss/+ 10 lbs.
- Weight gain/+15 lbs
- Fever
- Chills
- Fatigue
- Nausea
- Other

Eyes, Ears, Nose & Throat:

- Impaired sight
- Eye disease
- Eye pain
- Vision problems
- Eye infections – freq.
- Glaucoma
- Hearing loss
- Ringing in ears
- Ear infections
- Dizzy spells
- Fainting spells
- Nose bleeds
- Breathing difficulty
- Sinus problems
- Sore throat
- Hoarseness
- Speech difficulties
- Dental problems
- Infected teeth (abs.)
- Other

Cardiovascular:

- Chest Pain
- Heart attack
- High blood pressure
- Open heart surgery
- Heart murmur
- Swelling ankles/feet
- Palpitations
- Irregular beat/pulse
- Pacemaker
- Mitral valve prolapse
- Angioplasty
- Artificial heart valve
- Rheumatic fever
- Circulation disorder
- High cholesterol
- Leg pain/walking
- Leg pain/ at rest
- Tiredness in legs
- Varicose vein
- Phlebitis
- Blocked arteries
- Cold, numb feet
- Angina – + occurrence
- Angina - + intensity
- Angina – new onset

Respiratory:

- Pneumonia/Pleurisy
- Bronchitis
- Asthma
- Shortness/ breath
- Tuberculosis
- Emphysema
- Allergies
- C.O.P.D
- Limited exercise tolerance
- Use of oxygen at home
- History smoking

Gastrointestinal:

- Loss of appetite
- Excessive hunger
- Excessive thirst
- Difficulty swallowing
- Heart burn
- Peptic ulcer
- Persistent nausea
- Vomiting
- Abdominal pain
- Gallbladder problem
- Liver problems
- Jaundice
- Hepatitis A
- Hepatitis B
- Hepatitis C
- Cirrhosis
- Diarrhea
- Diverticulosis
- Crohn's/colitis
- Bloody / black stool
- Heartburn/reflux esophaagitis
- Other

Bladder, Kidney:

- Frequent urination
- Bladder infections
- Blood in urine
- Kidney stone
- Renal failure
- Swelling feet

Female:

- Sexual transmissive disease
- Breast cancer
- Ovarian cancer
- Oral contraceptives

Male:

- Sexual transmissive disease
- Prostate cancer

Hematologic (Blood Disorders):

- Anemia
- Bruise easily
- Cancer
- Blood transfusion
- Sickle cell disease/ trait
- Take Coumadin

Endocrine:

- Diabetes
- Thyroid disease
- Osteoporosis

Neurological (Nervous):

- Seizures
- Tremor/hands shake
- Headaches/frequent
- Stroke
- Change in memory
- Trouble w/balance
- Spine disease
- Sciatica
- Numbness
- Muscle weakness
- Polio
- Change in sensation

Bone and Joint:

- Arthritis/Rheumatism
- Back pain-recurrent
- Gout
- Rheumatoid arthritis
- Artificial joints
- Osteoarthritis
- Severe arthritis of TMJ (jaw) or neck
- Osteoporosis

Skin:

- Rashes
- Hives
- Psoriasis
- Eczema
- Skin cancer
- New growths
- Color change mole/wart
- Thick scar or keloid formation
- Other

Psychiatric:

- Sleeping difficulty
- Concentration difficulty
- Depression
- Nervousness
- Agitation
- Memory loss
- Moodiness
- Suicidal idea
- Phobias
- Mental illness
- Feelings of worthlessness

Childhood Illnesses:

- Rheumatic fever
- Scarlet fever
- Chicken pox
- Mumps
- Measles
- Herpes

Immunology:

- HIV
- Weak immune system
- Chronic fatigue syndrome
- Frequent infections

Gulfcoast Foot and Ankle Center, Inc.

9955 Tamiami Trail North,
Suite 1, Naples, FL. 34108
(239) 566-8800 Fax (239) 566-8778

Physicians Regional Medical Center
6101 Pine Ridge Road, 3rd Floor
Naples, FL 34119
(239) 304-5161 Fax (239) 304-5193

3501 Health Center Blvd, #2150,
Bonita Springs, FL 34135
(239) 949-3399 Fax (239) 949-6553

❖ Office Financial Policy ❖
Gulfcoast Foot & Ankle Center, Inc.

- ❖ We are dedicated to providing the best possible care and service to you, while maintaining our patient's privacy and confidentiality. This requires your complete understanding of our financial policies as an essential element of your care and treatment. *If you have any questions, please discuss them with our front office staff.*
- ❖ We are Medicare participating providers. We will bill Medicare for you. You will be responsible for your annual deductible, co-payment and charges for non-covered services. You will be asked to sign an Advanced Beneficiary Notice form for services that we know are not covered by Medicare. Medicare does cover surgery, X-rays and some other types of foot care. Medicare **does not** cover routine foot care such as trimming of corns, calluses or cutting of toenails. You will need to pay for these services at the time they are provided.
- ❖ Unless other arrangements have been made in advance by you, or your health insurance carrier, payment for office services are due at the time of service. We will accept VISA, MasterCard, cash or check.
- ❖ Your insurance policy is a contract between you and your insurance company. As a courtesy, we will file your insurance claim for you if you assign the benefits to the doctor. In other words, you agree to have your insurance company pay the doctor directly. If your insurance company does not pay the practice within a reasonable period (60 days), you are responsible for payment. Please assist us in settling your claim by periodically calling your insurance carrier and requesting they pay us in a timely manner.
- ❖ We have made prior arrangements with some insurers and other health plans to accept an assignment of benefits. We will bill those plans with which we have an agreement and will only require you to pay the co-pay/co-insurance/deductible at the time of service. We will do our best to inform you of whether we accept or participate with your insurance company. This list changes frequently, so *please check your benefits with your insurance company.* We handle these claims in accordance with our agreement, if one exists. We file your insurance as a **courtesy**. In the event that we are not aware of a charge or service that is not covered by your plan, you will be billed after we receive a denial from your insurance company.
- ❖ There are certain elective surgical procedures that we require pre-payment. You will be informed in advance if your procedure is one of those. In that event, payment will be due one week prior to the surgery.
- ❖ You must inform the office of all insurance changes and authorization and referral requirements. In the event the office is not informed, you will be responsible for any charges denied.
- ❖ Past due accounts are subject to collection proceedings, including the filing of a Medical Lien. All fees including, but not limited to collection fees, attorney fees and court fees shall become your responsibility in addition to the balance due this office.
- ❖ If you have insurance coverage with a plan with which we do not have a prior agreement, we will prepare and send the claim for you on an unassigned basis as a **courtesy**. This means your insurer will send the payment directly to you. Therefore, all charges for your care and treatment are due at the time of service. If the charges exceed \$1,000 you will be asked to pay 40% of the entire bill with remaining balance payable in 45 days. This gives you time to file with your insurance company. Please understand that since we do not have a contract with your plan, we are not obligated to adjust our charges based on your plan's coverage or benefit schedule.
- ❖ All health plans are not the same and do not cover the same services. In the event your health plan determines a service to be "not covered," or you do not have an authorization, you will be responsible for the complete charge. We will attempt to verify benefits for some specialized services; however, you remain responsible for charges for all services rendered. Patients are encouraged to contact their plans for clarification of benefits prior to services rendered. We will not become involved in a dispute between you and your company regarding deductibles, co-payments, secondary insurances, usual and customary charges or medical necessity. We will supply factual information as necessary.
- ❖ There is a service fee of \$35.00 for all returned checks. Your insurance company does not cover this fee.
- ❖ Your signature below signifies that you understand and agree to our financial policy and your responsibility regarding charges incurred in this office.

Signature of Patient/Responsible Party: _____

Printed Name: _____ Date: _____

Patient Name (if different): _____

Witness: _____ Date: _____

Printed Name: _____

_____ Patient initials to indicate copy received

Gulfcoast Foot and Ankle Center, Inc.

9955 Tamiami Trail North,
 Suite 1, Naples, FL. 34108
 (239) 566-8800 Fax (239) 566-8778

Physicians Regional Medical Center
 6101 Pine Ridge Road, 3rd Floor
 Naples, FL 34119
 (239) 304-5161 Fax (239) 304-5193

3501 Health Center Blvd, #2150,
 Bonita Springs, FL 34135
 (239) 949-3399 Fax (239) 949-6553