

## Welcome to our Office

Last Name \_\_\_\_\_ First \_\_\_\_\_ MI \_\_\_\_\_ SS# \_\_\_\_\_

Birth Date \_\_\_\_\_ Sex \_\_\_\_\_ Age \_\_\_\_\_

Race: \_\_\_\_\_  I prefer not to answer  I do not know  
(White, American Indian, Asian, Black or African, Native Hawaiian, Hispanic, etc.)

Ethnicity \_\_\_\_\_  I prefer not to answer  I do not know

Preferred Language: \_\_\_\_\_  I prefer not to answer  I do not know

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 \_\_\_\_\_

Were you offered a copy of the HIPAA Privacy Practice Notice?  Yes  No

Do you want to be exempt from public reporting?  Yes  No

Can we send mail to the address on file?  Yes  No

Can we call the phone number on file?  Yes  No

Can we leave voicemail on answering machine?  Yes  No

Will you allow internet based delivery reminders like email?  Yes  No

Who can we leave messages with?  Husband  Wife  Daughter  Son  Other \_\_\_\_\_

How did you hear about us? \_\_\_\_\_

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, Ste 1,  
Naples, FL. 34108  
(239) 566-8800 Fax (239) 566-8778

Physicians Regional Medical Ctr  
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

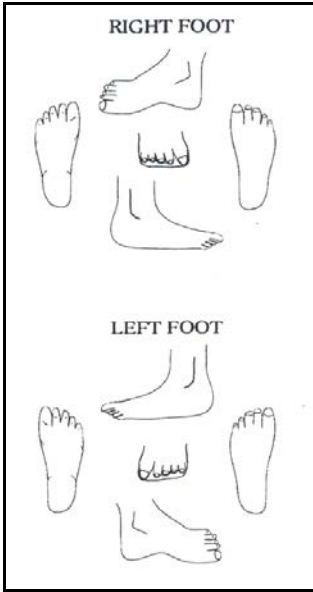
Name and telephone number of previous doctor(s) who treated your foot problem(s)

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

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# MEDICAL HISTORY

Height \_\_\_\_\_ Weight \_\_\_\_\_ Blood Pressure \_\_\_\_\_

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:**

- |  |                                      |   |                                      |   |
|--|--------------------------------------|---|--------------------------------------|---|
| <input type="checkbox"/> Any Antibiotic    | <input type="checkbox"/> Aspirin     | <input type="checkbox"/> Codeine          | <input type="checkbox"/> Cortisone   | <input type="checkbox"/> Food allergies |
| <input type="checkbox"/> Grass, mold, dust | <input type="checkbox"/> Hay fever   | <input type="checkbox"/> Local anesthesia | <input type="checkbox"/> Mercurials  | <input type="checkbox"/> Novocaine      |
| <input type="checkbox"/> Penicillin        | <input type="checkbox"/> Sulfa drugs | <input type="checkbox"/> Tape             | <input type="checkbox"/> Other _____ |   |

**No Known Allergies**

**Pharmacy:**

What pharmacy do you use? \_\_\_\_\_ Phone: \_\_\_\_\_

Location: \_\_\_\_\_

**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

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# MEDICAL HISTORY

## Review of systems (ROS)

Please check each item that applies to you.

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Abdominal pain           | <input type="checkbox"/> Eye pain                      | <input type="checkbox"/> Osteoarthritis                        |
| <input type="checkbox"/> Agitation                | <input type="checkbox"/> Fainting spells               | <input type="checkbox"/> Osteoporosis                          |
| <input type="checkbox"/> Allergies                | <input type="checkbox"/> Fatigue                       | <input type="checkbox"/> Other                                 |
| <input type="checkbox"/> Anemia                   | <input type="checkbox"/> Feelings of worthlessness     | <input type="checkbox"/> Ovarian cancer                        |
| <input type="checkbox"/> Angina - + intensity     | <input type="checkbox"/> Fever                         | <input type="checkbox"/> Pacemaker                             |
| <input type="checkbox"/> Angina – + occurrence    | <input type="checkbox"/> Frequent infections           | <input type="checkbox"/> Palpitations                          |
| <input type="checkbox"/> Angina – new onset       | <input type="checkbox"/> Frequent urination            | <input type="checkbox"/> Peptic ulcer                          |
| <input type="checkbox"/> Angioplasty              | <input type="checkbox"/> Gallbladder problem           | <input type="checkbox"/> Persistent nausea                     |
| <input type="checkbox"/> Arthritis/Rheumatism     | <input type="checkbox"/> Glaucoma                      | <input type="checkbox"/> Phlebitis                             |
| <input type="checkbox"/> Artificial heart valve   | <input type="checkbox"/> Gout                          | <input type="checkbox"/> Phobias                               |
| <input type="checkbox"/> Artificial joints        | <input type="checkbox"/> Headaches/frequent            | <input type="checkbox"/> Pneumonia/Pleurisy                    |
| <input type="checkbox"/> Asthma                   | <input type="checkbox"/> Hearing loss                  | <input type="checkbox"/> Polio                                 |
| <input type="checkbox"/> Back pain-recurrent      | <input type="checkbox"/> Heart attack                  | <input type="checkbox"/> Prostate cancer                       |
| <input type="checkbox"/> Bladder infections       | <input type="checkbox"/> Heart burn                    | <input type="checkbox"/> Psoriasis                             |
| <input type="checkbox"/> Blocked arteries         | <input type="checkbox"/> Heart murmur                  | <input type="checkbox"/> Rashes                                |
| <input type="checkbox"/> Blood in urine           | <input type="checkbox"/> Heartburn/reflux esophaagitis | <input type="checkbox"/> Renal failure                         |
| <input type="checkbox"/> Blood transfusion        | <input type="checkbox"/> Hepatitis A                   | <input type="checkbox"/> Rheumatic fever                       |
| <input type="checkbox"/> Bloody / black stool     | <input type="checkbox"/> Hepatitis B                   | <input type="checkbox"/> Rheumatoid arthritis                  |
| <input type="checkbox"/> Breast cancer            | <input type="checkbox"/> Hepatitis C                   | <input type="checkbox"/> Ringing in ears                       |
| <input type="checkbox"/> Breathing difficulty     | <input type="checkbox"/> Herpes                        | <input type="checkbox"/> Scarlet fever                         |
| <input type="checkbox"/> Bronchitis               | <input type="checkbox"/> High blood pressure           | <input type="checkbox"/> Sciatica                              |
| <input type="checkbox"/> Bruise easily            | <input type="checkbox"/> High cholesterol              | <input type="checkbox"/> Seizures                              |
| <input type="checkbox"/> C.O.P.D                  | <input type="checkbox"/> History smoking               | <input type="checkbox"/> Severe arthritis of TMJ (jaw) or neck |
| <input type="checkbox"/> Cancer                   | <input type="checkbox"/> HIV                           | <input type="checkbox"/> Sexual transmissive disease           |
| <input type="checkbox"/> Change in memory         | <input type="checkbox"/> Hives                         | <input type="checkbox"/> Shortness/breath                      |
| <input type="checkbox"/> Change in sensation      | <input type="checkbox"/> Hoarseness                    | <input type="checkbox"/> Sickle cell disease/trait             |
| <input type="checkbox"/> Chest Pain               | <input type="checkbox"/> Impaired sight                | <input type="checkbox"/> Sinus problems                        |
| <input type="checkbox"/> Chicken pox              | <input type="checkbox"/> Infected teeth (abs.)         | <input type="checkbox"/> Skin cancer                           |
| <input type="checkbox"/> Chills                   | <input type="checkbox"/> Irregular beat/pulse          | <input type="checkbox"/> Sleeping difficulty                   |
| <input type="checkbox"/> Chronic fatigue syndrome | <input type="checkbox"/> Jaundice                      | <input type="checkbox"/> Sore throat                           |
| <input type="checkbox"/> Circulation disorder     | <input type="checkbox"/> Kidney stone                  | <input type="checkbox"/> Speech difficulties                   |
| <input type="checkbox"/> Cirrhosis                | <input type="checkbox"/> Leg pain/ at rest             | <input type="checkbox"/> Spine disease                         |
| <input type="checkbox"/> Cold, numb feet          | <input type="checkbox"/> Leg pain/walking              | <input type="checkbox"/> Stroke                                |
| <input type="checkbox"/> Color change mole/wart   | <input type="checkbox"/> Limited exercise tolerance    | <input type="checkbox"/> Suicidal idea                         |
| <input type="checkbox"/> Concentration difficulty | <input type="checkbox"/> Liver problems                | <input type="checkbox"/> Swelling ankles/feet                  |
| <input type="checkbox"/> Crohn's/colitis          | <input type="checkbox"/> Loss of appetite              | <input type="checkbox"/> Swelling feet                         |
| <input type="checkbox"/> Dental problems          | <input type="checkbox"/> Measles                       | <input type="checkbox"/> Take Coumadin                         |
| <input type="checkbox"/> Depression               | <input type="checkbox"/> Memory loss                   | <input type="checkbox"/> Thick scar or keloid formation        |
| <input type="checkbox"/> Diabetes                 | <input type="checkbox"/> Mental illness                | <input type="checkbox"/> Thyroid disease                       |
| <input type="checkbox"/> Diarrhea                 | <input type="checkbox"/> Mitral valve prolapse         | <input type="checkbox"/> Tiredness in legs                     |
| <input type="checkbox"/> Difficulty swallowing    | <input type="checkbox"/> Moodiness                     | <input type="checkbox"/> Tremor/hands shake                    |
| <input type="checkbox"/> Diverticulosis           | <input type="checkbox"/> Mumps                         | <input type="checkbox"/> Trouble w/balance                     |
| <input type="checkbox"/> Dizzy spells             | <input type="checkbox"/> Muscle weakness               | <input type="checkbox"/> Tuberculosis                          |
| <input type="checkbox"/> Ear infections           | <input type="checkbox"/> Nausea                        | <input type="checkbox"/> Use of oxygen at home                 |
| <input type="checkbox"/> Eczema                   | <input type="checkbox"/> Nervousness                   | <input type="checkbox"/> Varicose vein                         |
| <input type="checkbox"/> Emphysema                | <input type="checkbox"/> New growths                   | <input type="checkbox"/> Vision problems                       |
| <input type="checkbox"/> Excessive hunger         | <input type="checkbox"/> Nose bleeds                   | <input type="checkbox"/> Vomiting                              |
| <input type="checkbox"/> Excessive thirst         | <input type="checkbox"/> Numbness                      | <input type="checkbox"/> Weak immune system                    |
| <input type="checkbox"/> Eye disease              | <input type="checkbox"/> Open heart surgery            | <input type="checkbox"/> Weight gain/+15 lbs                   |
| <input type="checkbox"/> Eye infections – freq.   | <input type="checkbox"/> Oral contraceptives           | <input type="checkbox"/> Weight loss/+ 10 lbs.                 |

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**❖ 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, Discover, 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**

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