

# Medical and Surgical Foot and Ankle Care, PC

**(303) 932-7957**

## PATIENT INFORMATION (Please Print and bring with you.)

Patient Name \_\_\_\_\_ DOB \_\_\_\_\_ Age \_\_\_\_\_

Home Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Male: \_\_\_ Female \_\_\_ Marital Status: S \_\_\_ M \_\_\_ W \_\_\_ D \_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_ Shoe Size: \_\_\_\_\_

Employer: \_\_\_\_\_ Social Security # \_\_\_\_\_

Email Address: \_\_\_\_\_

Guarantor Name: \_\_\_\_\_ DOB \_\_\_\_\_ Guarantor Phone #: \_\_\_\_\_

Guarantor Employed By: \_\_\_\_\_ Work Phone \_\_\_\_\_ SSN: \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Phone #: \_\_\_\_\_

### How did you find out about our office?

Name: \_\_\_\_\_ Address: \_\_\_\_\_

Other: \_\_\_\_\_

## MEDICAL INFORMATION

Family Doctor \_\_\_\_\_ Ph#: \_\_\_\_\_ Date of Last Visit \_\_\_\_\_

Pharmacy Name: \_\_\_\_\_ Pharmacy Phone # \_\_\_\_\_

Please describe your foot/ankle problem and how long you've had it:

\_\_\_\_\_

List all Allergies \_\_\_\_\_

\_\_\_\_\_

List all medications including over the counter and herbal supplements:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Have you had any serious illness or operation? Yes \_\_\_\_\_ No \_\_\_\_\_ Explain: \_\_\_\_\_

\_\_\_\_\_

List surgeries and dates: \_\_\_\_\_

\_\_\_\_\_

Do you smoke: Yes No In the past: Yes No Packs per day \_\_\_\_\_ Quit Date \_\_\_\_\_

Do you drink alcohol? Yes No Drinks per week \_\_\_\_\_

Family History of specific Illness: \_\_\_\_\_

\_\_\_\_\_

**PLEASE MARK ANY CONDITION WHICH PERTAINS TO YOU:**

<input type="checkbox"/> Anemia	<input type="checkbox"/> Circulation	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Osteoporosis
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Dementia	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Recurrent Infections
<input type="checkbox"/> Asthma	<input type="checkbox"/> Depression	<input type="checkbox"/> High Cholesterol	<input type="checkbox"/> Skin Condition
<input type="checkbox"/> Autoimmune Disorder	<input type="checkbox"/> Diabetes	<input type="checkbox"/> HIV/Aids	<input type="checkbox"/> Stomach Problem
<input type="checkbox"/> Bleeding Tendency	<input type="checkbox"/> Fibromyalgia	<input type="checkbox"/> Hypothyroidism	<input type="checkbox"/> Stroke
<input type="checkbox"/> Blood Clots	<input type="checkbox"/> Gastric Ulcers	<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Cancer	<input type="checkbox"/> Gout	<input type="checkbox"/> Liver Trouble	<input type="checkbox"/> Varicose Veins
<input type="checkbox"/> Chronic Back Pain	<input type="checkbox"/> Healing Problems	<input type="checkbox"/> Lung Disease	
	<input type="checkbox"/> Heart Disease		

**REVIEW OF SYSTEMS**

Please circle YES or NO to indicate if you currently have any problems in one of more of the following areas. If yes, please explain or describe the problem:

General/Constitutional (fever, weight loss or gain, tired feeling) \_\_\_\_\_ YES NO

Eyes (blurred vision, eye pain, discharge, etc) \_\_\_\_\_ YES NO

Ears, Nose, Throat, Mouth (hearing loss, ear ache, nasal congestion, chronic cough, nasal drip, dry mouth, allergies, hay fever, etc) \_\_\_\_\_ YES NO

Respiratory (asthma, emphysema, chronic bronchitis, wheezing, shortness of breath, etc) \_\_\_\_\_ YES NO

Cardiovascular (hypertension, heart problems) \_\_\_\_\_ YES NO

Gastrointestinal (diarrhea, constipation, hernia, ulcers, etc) \_\_\_\_\_ YES NO

Genitourinary (painful urination, frequent urination, impotence, etc) \_\_\_\_\_ YES NO

Lymphatic (anemia, bleeding problems, problems with blood transfusions, etc) \_\_\_\_\_ YES NO

Endocrinology (hypothyroidism, diabetes mellitus) \_\_\_\_\_ YES NO

Musculoskeletal (arthritis, joint pain, swelling, cramps, stiffness) \_\_\_\_\_ YES NO

Skin (pimples, warts, growths, rashes, etc) \_\_\_\_\_ YES NO

**REFERRAL AND NON-COVERED FOOT CARE**

If your insurance is a part of a Managed Care plan (HMO, POS, EPO, etc), failure to obtain a valid referral from your primary care physician (PCP) may result in reduced or non-payment of benefits.

Your insurance carrier may determine that your foot care is an excluded service, in which no reimbursement will be made. Should this occur, the responsibility of payment for these services, will remain yours. This includes orthotics, splints, over the counter medications, heel cups, pads, toe separators, or any other equipment received that insurance carrier may not pay.

**ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES**

I authorize use of this form on all my insurance submissions and release of information to all my insurance companies. I acknowledge responsibility for payment of any deductibles, co-insurance and unauthorized or non-covered services. I accept responsibility for any unpaid bills sixty days after insurance is filed. If for any reason the account becomes delinquent, I agree to pay for all collection and legal fees. I authorize Keith Naftulin, DPM, PC, to act as my agent in helping me obtain payment from my insurance company. I request payment of my insurance benefits to be made directly to Keith Naftulin, DPM, PC for any services furnished to me by that physician. I permit a copy of this authorization to be used in place of the original. I hereby give permission to Keith Naftulin, DPM, PC to examine and administer treatment after consultation and perform such procedures as may be deemed necessary in the diagnosis and/or treatment of my condition.

I acknowledge that I was provided a copy of the Notice of Privacy Practices from Keith Naftulin, DPM, PC and that I have read and understand the Notice.

Signature of Patient or Legal Representative \_\_\_\_\_ Date: \_\_\_\_\_