Foot and Ankle Specialist of Ohio

Dr. Gladys G. deLeon * Dr. Stephen J. Frania * Sarah Small, CNP
Podiatric & Sports Medicine/Reconstructive Foot & Ankle Surgery
www.fasohio.com

Today's Date: _____

Please complete the following information and the next couple pages. All information is strictly confidential.
(Please print clearly)

General Information

Patient's name: _____
(Last) (First) (Middle Initial)

Address: _____ _____ _____ _____
(Street/Apt) (City) (State) (Zip)

Home Ph. ( ) _____ Cell Ph. ( ) _____ Work Ph. ( ) _____

SSN: _____ Date of Birth: _____ Age: _____ yrs. Male____ Female_____

Email: _____ Employer: _____

Responsible Party if Minor: _____ Phone no: _____

Address (If Different from above) _____

Emergency Contact: _____ Relationship: _____ Phone no: _____

Primary Doctor: _____ Referred by: _____

Marital Status: (Single _____) (Married _____) (Divorced _____) (Widowed _____) (Other _____)
Race: (African American ____) (White _____) (Asian _____) (Hispanic_____) (American Indian _____) (Other _____)
Ethnicity: (Hispanic or Latino _____) (Not Hispanic or Latino _____) (Patient Declined to Answer _____)

Pharmacy: (Name & Address) _____

Insurance Information

Primary Insurance Company: _____

ID #:_____ Group #: _____

Insured Name (Exactly as it reads on the card) _____ DOB:_____

Secondary Insurance Company: _____

ID #: _____ Group #: _____

Insured Name (Exactly as it reads on the card): _____ DOB: _____

CONSENT AND UNDERSTANDING

This consent is required by the Health Insurance Portability and Accountability Act of 1996 to inform you of your rights for privacy with respect to your health care information.

CONSENT RELATED to PRIVACY NOTICE:

I have had a chance to review the Practice Privacy Notice as part of this registration process. I understand that the terms of the Privacy Notice may change and I may obtain these revised notices by contacting the practice by phone or in writing. I understand I have the right to request how my protected health information (PHI) has been disclosed. I also have the right to restrict how this information is disclosed, but this practice is not required to agree to my restrictions. If it does agree to my restrictions on PHI use, it is bound by that agreement.

CONSENT FOR CARE:

I, with my signature, authorize (this practice) and any employee working under the direction of the physician to provide medical care for me, or to this patient for which I am the legal guardian. This medical care may include services and supplies related to my health (or the identified person) and may include (but not limited to) preventive, diagnostic, therapeutic, rehabilitative, maintenance, palliative care, counseling, assessment or review of physical or mental status/function of the body and the state or dispensing of drugs, devices, equipment or other items required and in accordance with a prescription. This consent includes contact and discussion with other health care professional for care and treatment.

CONSENT FOR RELEASE OF INFORMATION AND ASSIGNMENT OF BENEFITS:

I authorize this practice to furnish information to the identified insurance carrier(s) for any and all payment activities. I consent to assign all payments for services directly to this practice. I further consent to the use of my protected health information for any practice operational needs as identified in the Practice Privacy Notice. I authorize this practice to freely discuss my protected health information, including insurance and/or billing questions, chart information, test results, or appointment issues ONLY with the following individual(s):

_____

FINANCIAL POLICY:

We appreciate you choosing us for your healthcare. We will adhere in the following financial policy in order to consistently deliver high quality care and services. The patient/responsible party assumes responsibility to ensure that the financial obligation is fulfilled for the health care services received.

I understand that I am responsible for all co-payments, amounts applied to deductibles and other amounts that may be deemed my responsibility by the payment sources as required by my contract with my insurance plan and state regulations.

- I understand that if I have an insurance co-payment, I am expected to make payment when checking in for my appointment.
- I understand that my contract with my insurance entity may or may not cover some services. All insurance policies are not the same. They vary by employer group. Foot and Ankle Specialists of Ohio, Inc is not responsible or able to know every policy available. It is my responsibility to verify applicable coverage prior to receiving the services. If I seek care outside of the contract terms, I am aware that I may be responsible for all charges that are incurred.
- I understand I am responsible for obtaining a referral, if applicable.
- I understand that I will be responsible for any and all costs associated with my account going to collections. This may include a 30% collection fee, attorney fees, legal fees, ect.

******I understand that after a 3rd missed/cancelled appointment, that a $25.00 fee will be assessed and that I will need to pay this fee prior to re-scheduling another appointment. I understand that this fee will be waived ONLY if more than 24 hours notice is given when an appointment has been cancelled or re-scheduled.**

Foot and Ankle Specialist of Ohio, Inc is a physician independently owned and operated facility

Thank you for your understanding and cooperation with this policy. It is our privilege to provide your medical care.

I have read and understand the Consents and Financial Policy stated above and agree to accept full responsibility as described above

_____ _____

Patient/Responsible Party Date

Patient name if different from Responsible Party_____

Patient Name: _____ Date: _____

Medical Information

Height: _____Weight: _____ Shoe Size: _____ Previous Podiatrist: _____

Are you diabetic? _____ If yes, what type? Type I or Type II

Who is managing your diabetes? Doctor Name: _____ Date Last Seen: _____

Please list other medical problems you have: _____

_____

What is your main foot/ ankle problem today: _____

_____

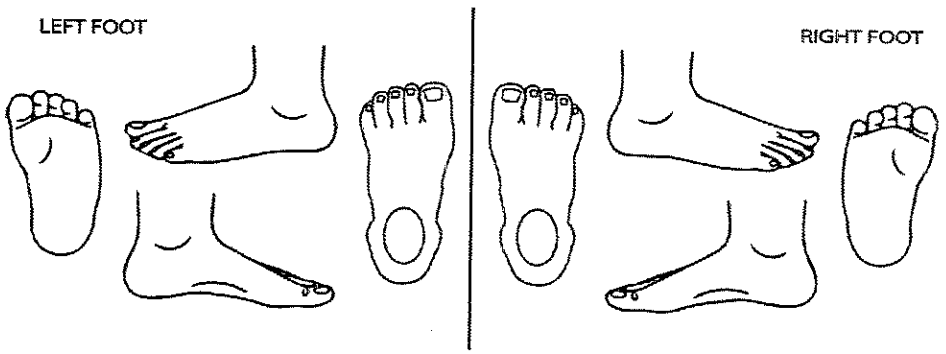
When did your main problem begin?: _____ Have you had any treatment?: _____

Is the pain: []Burning []Throbbing []Sharp []Dull []Aching []Tingling [] Numbness []Itching [] Other _____

How severe is your pain? 0 1 2 3 4 5 6 7 8 9 10

[No Pain] Please Circle [Extreme Pain]

Please indicate where your problem is located:



Social History

Do you smoke? Yes No How often? Never Occassionally Sometimes

Do you drink alcohol? Yes No How often? Never Occassionally Sometimes

Are you pregnant? Yes No How far along are you? _____

Family History

Father: Diabetic [] Arthritis [] Circulation Problems [] Heart Disease [] Cancer [] Decesased []

Mother: Diabetic [] Arthritis [] Circulation Problems [] Heart Disease [] Cancer [] Decesased []

Sibling: Diabetic [] Arthritis [] Circulation Problems [] Heart Disease [] Cancer [] Decesased []

Children: Diabetic [] Arthritis [] Circulation Problems [] Heart Disease [] Cancer [] Decesased []

Other: _____ Diabetic [] Arthritis [] Circulation Problems [] Heart Disease [] Cancer [] Decesased []

Patient Name: _____ Date: _____

Medication List

Please list medication and dosage. If you already have a list please provide copy to us.

Allergies

Please list all drug or food allergies including reaction.

Surgeries & Hospitalizations

Please list all previous surgeries & hospitalizations including dates.

REVIEW OF SYSTEMS

Patient Name: _____ DOB: _____ Date: _____

Are you experiencing or have you experienced any of the following? Please check all that apply.

CONSTITUTIONAL

- CHILLS
- WEAKNESS
- FATIGUE
- WEIGHT GAIN
- WEIGHT LOSS
- FEVER

HEAD

- DIZZINESS
- PAIN
- FAINTING
- SWEATS
- HEADACHES

RESPIRATORY

- ASTHMA
- BRONCHITIS
- COPD
- TB
- WHEEZING
- SHORTNESS OF BREATH

HEMATOLOGIC

- ANEMIA
- SLOW HEALING
- BLEED EASILY SWOLLEN GLAND(S)
- BLOOD CLOT

NEUROLOGICAL

- BURNING
- CHARCOT
- STROKE
- UNSTEADY GAIT
- NUMBNESS
- TINGLING

CARDIOVASCULAR

- CHEST PAIN
- HAIR LOSS ON LEGS
- RHEUMATIC FEVER
- LEG OR FOOT ULCERS
- VASCULAR GRAFTS
- VARICOSE VEINS
- HEART MURMUR
- CRAMPS IN LEGS/FEET
- PALPATIONS
- EXTREMITY(S) COLD
- HIGH BLOOD PRESSURE
- REPLACEMENT OF HEART VALVE
- HISTORY OF MYOCARDIAL INFARCTION

GASTROINTESTINAL

- LIVER DISEASE EXCESSIVE THIRST DIARRHEA
- GALL BLADDER DISEASE
- JAUNDICE
- ANTACID USE
- NAUSEA

SKIN

- ECZEMA
- DRYNESS
- ATHLETE'S FOOT KELOID SCAR
- RASH
- FUNGAL NAILS
- INGROWN NAILS
- WARTS

MUSCULOSKELETAL

- ARTHRITIS
- LOWER BACK PAIN JOINT PAIN
- RESTRCTED MOTION
- ARCH PAIN
- BUNIONS
- CORNS
- HAMMERTOES
- IN-TOEING
- NEUROMA
- TOE WALKING
- JOINT STIFFNESS
- KNEE PAIN
- MUSCLE CRAMPS
- WEAKNESS
- BROKEN ANKLE
- BROKEN FOOT
- CALLUSES
- FLAT FEET
- HEEL PAIN
- JOINT IMPLANTS
- ORTHOTIC USE
- GOUT
- BACK PROBLEMS
- PARALYSIS
- ANKLE SPRAIN
- GAIT (WALKING PROBLEMS)
- HIGH ARCH
- MUSCLE STIFFNESS
- SHOE INSERT USE