Chart #_____

Family Foot and Ankle Clinic, PA

3790 – 117th Lane NW
Coon Rapids, MN 55433

11855 Ulysses Street NE Suite #210
Blaine, MN 55434

763-421-7300

DATE _____

NAME: _____ _____ ___ DOB: ____/____/____ AGE: _____ SEX:
LAST FIRST MI

ADDRESS: _____CITY/STATE: _____ ZIP: _____

HOME PHONE #: _____ CELL PHONE #:_____

WORK PHONE #:_____

SPOUSE NAME_____SPOUSE DOB _____

E-MAIL ADDRESS: _____ PRIMARY LANGUAGE_____

SOCIAL SECURITY #_____ RACE_____

PRIMARY CARE CLINIC_____ PHONE: _____

PRIMARY CARE DOCTOR: _____

PHARMACY: _____ LOCATION: _____ PHONE #:_____

WHO REFERRED YOU TO US?_____

INSURANCE INFORMATION

*PRIMARY INSURANCE COMPANY NAME: _____

POLICY HOLDER NAME: _____ DATE OF BIRTH _____

ID # _____ GROUP # _____

*SECONDARY INSURANCE COMPANY NAME: _____

POLICY HOLDER NAME: _____ DATE OF BIRTH _____

ID # _____ GROUP # _____

MEDICATIONS: IF YOU HAVE A LIST PLEASE PROVIDE COPY TO FRONT DESK.

NAME DOSE HOW OFTEN DO YOU TAKE?

_____

_____

_____

_____

_____

***ARE YOU CURRENTLY ON A CHRONIC PAIN MEDICATION CONTRACT**? YES ☐ NO ☐

Please provide provider name and Phone #_____

***Allergies:** Medications_____

☐ FOODS _____ ☐ TAPE ☐ LATEX ☐ SHELLFISH ☐ IODINE ☐ OTHER

☐ **NO KNOWN ALLERGIES**

Revised June 2016

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PLEASE LIST ALL PRIOR SURGERIES:

TYPE OF SURGERY	DATE	TYPE OF SURGERY	DATE
_____		_____	
_____		_____	
_____		_____	

SOCIAL HISTORY

MARITAL STATUS: ☐ SINGLE ☐ MARRIED ☐ PARTNERED ☐ SEPARATED ☐ DIVORCED ☐ WIDOWED

USE OF ALCOHOL: ☐ NEVER ☐ NO LONGER USE ☐ HISTORY OF ALCOHOL ABUSE
☐ CURRENT USE - TYPE _____ ☐ RARE ☐ OCCASIONAL ☐ MODERATE ☐ DAILY

USE OF TOBACCO: ☐ NEVER ☐ QUIT – HOW LONG AGO? _____ ☐ SMOKE ____ PACKS/DAY FOR ____ YEARS

USE OF RECREATIONAL DRUGS: ☐ NEVER ☐ QUIT – HOW LONG AGO? _____ TYPE _____
☐ CURRENT USE - TYPE _____ ☐ RARE ☐ OCCASIONAL ☐ MODERATE ☐ DAILY

EMPLOYER: _____ OCCUPATION: _____

HOW MUCH ARE YOU ON YOUR FEET AT WORK? ☐ 10% ☐ 25% ☐ 50% ☐ 75% ☐ 100%

YOUR MEDICAL HISTORY

HEIGHT: _____ WEIGHT: _____SHOE SIZE: _____

HAVE YOU EVER BEEN DIAGNOSED WITH ANY OF THE FOLLOWING?

☐	ACID REFLUX	☐	FIBROMYALGIA	☐	NEUROPATHY
☐	ANEMIA	☐	GOUT	☐	OPEN SORES
☐	ARTHRITIS	☐	HEART ATTACK	☐	PNEUMONIA
☐	ASTHMA	☐	HEART DISEASE	☐	POLIO
☐	BLADDER INFECTIONS	☐	HEPATITIS	☐	RHEUMATIC FEVER
☐	ABNORMAL BLEEDING	☐	HIV+/AIDS	☐	SLEEP APNEA
☐	BLOOD CLOTS	☐	HIGH BLOOD PRESSURE	☐	STROKE
☐	CANCER	☐	KIDNEY DISEASE	☐	THYROID DISEASE
☐	DIABETES	☐	LIVER DISEASE		

TO THE BEST OF MY KNOWLEDGE, I HAVE ANSWERED THE QUESTIONS ON THIS FORM ACCURATELY. I UNDERSTAND THAT PROVIDING INCORRECT INFORMATION CAN BE DANGEROUS TO MY HEALTH. I UNDERSTAND THAT IT IS MY RESPONSIBILITY TO INFORM THE DOCTOR AND OFFICE STAFF OF ANY CHANGES IN MY MEDICAL STATUS.

_____ _____
PRINT NAME OF PATIENT, PARENT OR GUARDIAN — IF OTHER THAN PATIENT, RELATIONSHIP TO PATIENT

_____ _____
SIGNATURE — DATE

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WAS THIS PROBLEM CAUSED BY AN INJURY? ☐ NO ☐ YES (DESCRIBE) _____
_____

IF YES, WAS IT A WORK-RELATED INJURY? ☐ YES ☐ NO DATE OF INJURY_____

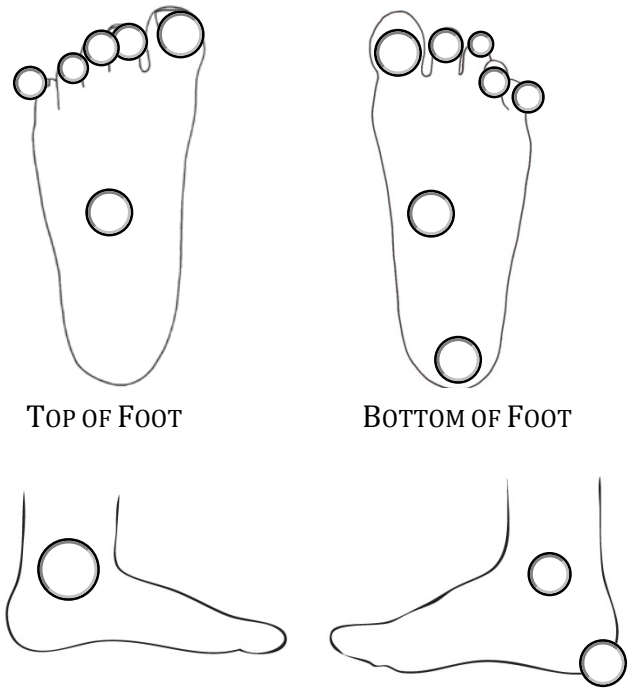
CURRENT PROBLEM: WHAT BRINGS YOU INTO OUR OFFICE TODAY?

_____

_____

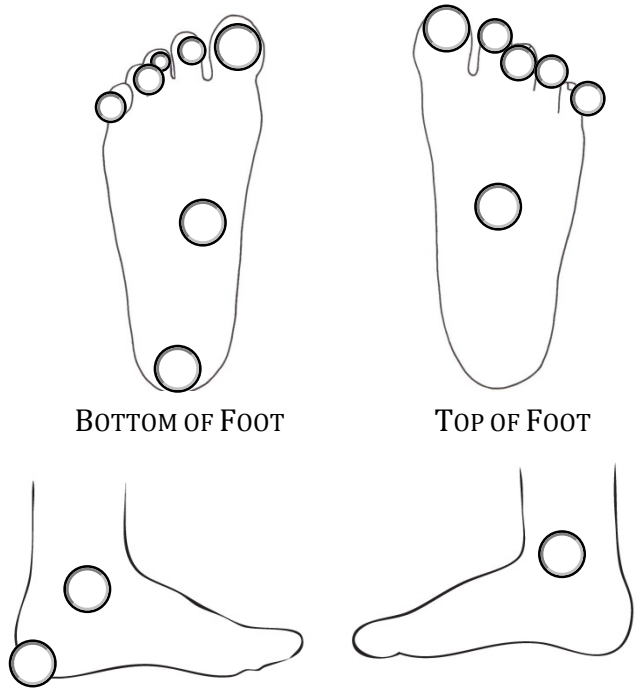
WHERE IS THE PAIN OR PROBLEM LOCATED? PLEASE MARK ON THE PICTURES BELOW.

LEFT FOOT



TOP OF FOOT BOTTOM OF FOOT

RIGHT FOOT



BOTTOM OF FOOT TOP OF FOOT

HOW LONG HAVE YOU HAD THIS PROBLEM? _____ DAYS / WEEKS / MONTHS / YEARS

DID YOUR PAIN OR PROBLEM: ☐ BEGIN ALL OF A SUDDEN ☐ DEVELOPED OVER TIME

HOW WOULD YOU DESCRIBE YOUR PAIN? ☐ NO PAIN ☐ SHARP ☐ DULL ☐ ACHING ☐ BURNING
☐ RADIATING ☐ ITCHING ☐ STABBING ☐ OTHER _____

HOW WOULD YOU RATE YOUR PAIN ON A SCALE FROM 0 TO 10? (PLEASE CIRCLE)
(NO PAIN) ◯ ◯ ◯ ◯ ◯ ◯ ◯ ◯ ◯ ◯ ◯ *(WORST PAIN POSSIBLE)*

WHAT MAKES YOUR PAIN OR PROBLEM FEEL WORSE? ◯ WALKING ◯ STANDING ◯ DAILY ACTIVITIES
◯ RESTING ◯ DRESS SHOES ◯ HIGH HEELS ◯ FLAT SHOES ◯ ANY CLOSED TOE SHOE
◯ RUNNING

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Patient Financial Policy

Your understanding of our financial policies is an essential element of your care and treatment. If you have any questions, please discuss them with our front office staff or supervisor.

- As our patient, you are responsible for all authorizations/referrals needed to seek treatment in this office.
- 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, we will have to look to you for payment.
- We have made prior arrangements with certain 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 or deductible.
- 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 or referrals; however, you remain responsible for charges to any service rendered. Patients are encouraged to contact their plans for clarification of benefits prior to services rendered.
- You must inform the office of all-insurance changes and authorization/referral requirements. In the event the office is not informed, you will be responsible for any charges denied.
- For most services provided in the hospital, we will bill your health plan. Any balance due is your responsibility.
- Past due accounts are subject to collection fees of 33%. All costs incurred including, but not limited to, collection fees, attorney fees and court fees shall be your responsibility in addition to the balance due this office.
- There is a service fee of $25.00 for all returned checks. Your insurance company does not cover this fee.

❖

Signature of Patient/Responsible Party: _____

Printed Name of Patient/Responsible Party _____ Date: _____

Medical Record Release

I hereby authorize the release of any information by **Family Foot and Ankle Clinic, PA** to my physician, insurance company and immediate family on behalf of myself and or dependents.

Signature of Patient/Responsible Party: _____

Printed Name of Patient/Responsible Party _____ Date: _____

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I ACKNOWLEDGE THAT I WAS PROVIDED A COPY OF THE NOTICE OF PRIVACY PRACTICES AND THAT I HAVE READ (OR HAD THE OPPORTUNITY TO READ IF I SO CHOSE) AND UNDERSTAND THE NOTICE.

***NOTICES ARE POSTED IN THE WAITING AREA OR A WRITTEN COPY CAN BE OBTAINED AT THE FRONT DESK.**

_____

PATIENT PRINTED NAME

_____

PARENT OR AUTHORIZED REPRESENTATIVE (IF APPLICABLE)

_____ _____

SIGNATURE **DATE**