PINNACLE
Foot and Ankle Centers

Patient Information

Patient Name:_____

Social Security #: _____ Age: _____

Date of Birth: _____ Sex: ☐ Male ☐ Female

Street Address:_____

City, State & Zip Code: _____

Preferred Phone Number: _____ Secondary Phone Number:_____

Race: ☐ American Indian/Alaska Native ☐ Asian ☐ Black/African American ☐ Hawaiian/Pacific Islander ☐ White

Ethnicity: ☐ Hispanic/Latino ☐ Not Hispanic/Latino Primary Language: ☐ English ☐Spanish ☐ Other

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed Email:

_____

How did you hear about the practice? ☐ Internet/Google ☐ Friend/Family ☐ Insurance Company

☐ Doctor Referral (who?) _____ ☐ Facebook ☐ Other _____

Primary Care Physician:_____ Date of Last Visit: _____

Referring Physician:_____

Emergency Contact: _____

(Name) (Phone) (Relationship)

Insurance Information

Primary Insurance: _____

(Company Name) (Member ID)

Secondary Insurance: _____

(Company Name) (Member ID)

Insurance Subscriber Information

(If different than patient)

Name: _____ Date of Birth: _____ Relationship to patient: _____

Allergies: _____ _____

_____ _____

_____ _____

☐ **No known allergies**

Local Pharmacy

_____

(Name) (Location)

Medications

Please list any medications you take including the dosages

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Family History

Please list any relevant family medical history and their relationship to you as well as which side of your family they are on (maternal or paternal)

Arthritis

☐ Mother ☐ Father ☐ Son ☐ Daughter
☐ Grandmother ☐ Grandfather ☐ Aunt ☐ Uncle

Cancer

☐ Mother ☐ Father ☐ Son ☐ Daughter
☐ Grandmother ☐ Grandfather ☐ Aunt ☐ Uncle

Diabetes

☐ Mother ☐ Father ☐ Son ☐ Daughter
☐ Grandmother ☐ Grandfather ☐ Aunt ☐ Uncle

Heart Disease

☐ Mother ☐ Father ☐ Son ☐ Daughter
☐ Grandmother ☐ Grandfather ☐ Aunt ☐ Uncle

Other _____

☐ Mother ☐ Father ☐ Son ☐ Daughter

☐ Grandmother ☐ Grandfather ☐ Aunt ☐ Uncle

Immunization History

Have you received a flu vaccine in the last year? ☐Yes ☐No
Date of last flu vaccine:_____
Have you received a pneumonia vaccine in the last year? ☐Yes ☐No
Date of last pneumonia vaccine:_____

Medical History

☐Anemia	☐Arthritis	☐COPD	☐Cancer
☐Dementia	☐Diabetes	☐Gout	☐Hepatitis
☐High Cholesterol	☐HIV	☐Hypertension	☐Stroke
☐TB	☐Thyroid Disease		

Other(s):_____

If you are Diabetic please answer the questions below
When were you diagnosed?_____ What was your last A1C reading?_____

Social History

Do you currently use tobacco? ☐Yes ☐No
If yes, what type do you use?_____ How much do you use?_____
History of tobacco use? ☐Yes ☐No
If yes, what type did you use? _____ When did you quit? _____
Do you drink alcoholic beverages? ☐Yes ☐No
If yes, how often do you drink? _____

Employment: ☐ Full time ☐ Part time ☐ Unemployed ☐ Retired

Marital status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Who do you live with?
☐ Alone ☐ Spouse/Partner ☐ Children ☐ Parent ☐ Relative ☐ Roommate

Have you had any falls within the last year? ☐Yes ☐No
Do you worry about falling when walking or standing? ☐Yes ☐No
Do you feel unsteady when walking or standing? ☐Yes ☐No

Surgical History (Please list any past surgeries below)

_____ _____
_____ _____
_____ _____

Height:_____ **Weight:**_____ **Shoe size:**_____

Please give a brief description in your own words of why you are here today:

_____
_____

Review of Systems:
(Please mark all that apply)

Constitutional
☐ Chills
☐ Fatigue
☐ Fever
☐ Weakness

Head
☐ Dizziness
☐ Fainting
☐ Head Injury
☐ Headaches(chronic)

Eyes
☐ Blurry Vision
☐ Cataracts
☐ Glaucoma

Respiratory
☐ Asthma
☐ Bronchitis
☐ Cough
☐ Shortness of Breath
☐ Wheezing

Cardio
☐ Chest Pain
☐ Cool Extremities
☐ Discolored Extremities
☐ Hair Loss on Legs
☐ High Blood Pressure
☐ Leg Pain When Walking
☐ Palpitations
☐ Swelling in Legs
☐ Ulcers on Legs
☐ Varicose Veins

Gastrointestinal
☐ Abdominal Pain
☐ Bloody Vomit/Stools
☐ Diarrhea
☐ Excessive Thirst
☐ Heartburn
☐ Hepatitis
☐ Jaundice
☐ Nausea
☐ Vomiting

Musculoskeletal
☐ Arthritis
☐ Back Pain
☐ Deformities
☐ Gout
☐ Joint Pain
☐ Joint Stiffness
☐ Muscle Cramps
☐ Paralysis
☐ Restricted Motion
☐ Weakness

Skin
☐ Dryness
☐ Easy to Bruise
☐ Hives
☐ Itching
☐ Lumps
☐ Moles
☐ Nail Appearance Changes
☐ Nail Texture Changes
☐ Rashes
☐ Skin Color Changes

Neurological
☐ Burning
☐ Dizziness
☐ Fainting
☐ Memory Loss
☐ Numbness
☐ Paralysis
☐ Strokes
☐ Tingling
☐ Tremors
☐ Unsteady Gait(walking)

Endocrine
☐ Cold Intolerance
☐ Excessive Urination
☐ Fatigue
☐ Heat Intolerance
☐ Increased Thirst

☐ None of the above

Assignment of Benefits:
I authorize payment of medical benefits to the named provider(s) of professional services rendered. I authorize release of any medical information necessary to process this claim. I verify that the information and medical history listed on these pages are correct to the best of my knowledge. I give my permission to the named prover(s) at Pinnacle Foot and Ankle Centers, LLC to perform and administer any necessary procedures.

_____

Signature of patient or guardian Date

Notice of Financial Policy

The following sets forth the general financial/billing policy of PInnacle Foot and Ankle Centers. Please review this information and initial each section to verify you have read and agree to the financial terms. Inability to initial any section or sign this page may result in cancellation of your appointment and an inability to be see by our physician.

- I understand that it is my responsibility to provide the of office of Pinnacle Foot and Ankle Centers, LLC any information relevant to my treatment at the time of check in and that it is my responsibility to notify Pinnacle Foot and ANkle Centers, LLC of any changes in this information

- I understand that it is my responsibility to know my specific co-pays, deductibles, and coinsurance and to pay services being rendered. (Benefits may differ from primary care benefits)

- I understand that I will be responsible for a $25 No-Show fee for any appointment(s) I do not show up for without 24 hour notice to the office of Pinnacle Foot and Ankle Centers, LLC

- I understand that there is a $35 fee to complete disability paperwork associated with my care. I will be provided a standard form of charge, however, if additional disability forms (such as FMLS) require completion, I understand that a $35 fee is required.

- I understand that Pinnacle Foot and Ankle Centers, LLC will verify my insurance eligibility, deductible amounts, and co-insurance amounts prior to any elective surgery I may have. I am aware that this is done as a courtesy and is not the responsibility of Pinnacle Foot and Ankle Centers, LLC. I further understand that the fee I am quoted is an estimate based on the anticipated surgery to be performed and current information provided to GBFA, LLC by my insurance carrier and is due on the date of service.

- I understand that I will be billed for any amounts due by me that were not collected on the date of service and that I have the responsibility to pay these amounts. I understand that I will be provided with three statements for any balance due after insurance payment. I further understand that if I have not made payment prior to the third statement, I will be sent to collections. I also understand that I will be responsible for any collections interest and any legal expenses with collection efforts.

- I understand that Pinnacle Foot and Ankle Centers, LLC will obtain the necessary prior authorization to rendering treatment. I further understand that prior authorization is not a guarantee of payment and that I am responsible for any bills not paid by my insurance carrier.

I verify that I have personally reviewed the above information:

Patient/Guardian Signature	Patient/Guardian Printed Name	Date

HIPAA Acknowledgement

I understand that I have a right to review Pinnacle Foot and Ankle Centers (PFAC) notice of privacy practices prior to this consent. I understand that Pinnacle Foot and Ankle Centers reserves the right to change their notices and practices and I will be given a new notification if this occurs. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations and that the organization is not required to agree to restrictions when requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon.

I understand that I am releasing all or any part of my medical records for the purpose of treatment, payment, or practice operations. This release may include records containing information regarding the diagnoses and/or treatment of HIV/AIDs, mental illness, and/or drug or alcohol abuse to any person(s) or corporation(s) which is or may be liable under contract for all or part of the medical changes including, but not limited to: Medicare, Medicaid, DSHS, private health insurance programs, public public health insurance programs,reviewing agencies, worker compensation carriers, welfare or patient's employer. The records may be needed in order to process a claim for medical services.

I authorize Pinnacle Foot and Ankle Centers, LLC to release information needed for billing purposes to entities that may provide services pertaining to my physician visit, such as reference laboratories.

Patient/Guardian Signature | Patient/Guardian Printed Name | Date

Release of Information

Person(s) listed below will be authorized to any and all records including medical information, billing information, and appointment information.

(Name) (Relationship)

(Name) (Relationship)

(Name) (Relationship)

Staff Use Only

Documentation of failure to obtain signed acknowledgement

I presented this acknowledgment to the patient. The patient refused to provide signature when requested

Staff Signature | Printed Name | Date