Welcome

FLAT SHOALS FOOT & ANKLE CENTER, LLC

PATIENT INFORMATION

Date: ________ Patient SS# N/A

Patient Name: ____________________

Address: ____________________

____

City State Zip Code

Sex: ☐ M ☐ F Age: ____ Date of Birth: ____________

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

Occupation: ____________________

Employer: ____________________

Employer Address: ____________________

Employer Phone: ____________________

Spouse's Name: ____________________

Whom may we thank for referring you? ____________________

PHONE NUMBERS

Home: ____________ Work/Cell: ____________

Email Address: ____________________

In case of emergency, contact: ____________________

Phone Number: ____________________

INSURANCE

Policy Owner: ____________________

Date of Birth: ____________________

Insurance Co: ____________________

Group # ____________ ID # ____________

Secondary Insurance Co: ____________________

Secondary Policy Owner D.O.B. ____________________

ASSIGNMENT & RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage with the above company and assign to Dr. Clements, and/or to Flat Shoals Foot & Ankle Center all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize release of all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

____
Responsible Party Signature

____________________ ____________
Relationship Date

MEDICARE AUTHORIZATION

I request that payment of authorize Medicare benefits be made either to me or on my behalf to Dr. Clements and/or Flat Shoals Foot & Ankle Center for any services furnished to me by them. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA-1500 form or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, co-insurance, and noncovered services. Co-insurance and deductible are based upon the charge determination of the Medicare carrier.

____________________ ____________
Beneficiary Signature Date

PODIATRIC HISTORY

What is the chief complaint for which you came to be treated? (Include foot, ankle, leg, knee, thigh and hip complaints.)

____

____

Have you been to a Podiatrist/Foot Dr. before? ☐ Yes ☐ No

If yes, please list:

Name: ____________________

Last Visit: ____________________

Is there any personal or family history of diabetes? ☐ Yes ☐ No

Alcohol: ____________________

Cigarette/Tobacco use: ____________

Years smoked: ____________

Athletic activities in which you participate (please list and indicate frequency)

____

____

____

Please indicate which foot problems you now have or have had in the past.

Problem	Yes	No
Ankle Pain	☐ Yes	☐ No
Athletes Foot	☐ Yes	☐ No
Bunions	☐ Yes	☐ No
Corns & Calluses	☐ Yes	☐ No
Cramps or Numbness in Feet or Legs	☐ Yes	☐ No
Flat Feet	☐ Yes	☐ No
Foot or Leg Cramps	☐ Yes	☐ No
Heel Pain	☐ Yes	☐ No
Ingrown Toenails	☐ Yes	☐ No
Plantar Warts	☐ Yes	☐ No
Swelling in Ankles or Feet	☐ Yes	☐ No
Tired Feet	☐ Yes	☐ No

Medical History

Place a mark on "Yes" or "No" to indicate if you have any of the following:

Condition	Yes	No	Condition	Yes	No	Condition	Yes	No
AIDS/HIV	❑ Yes	❑ No	Epilepsy	❑ Yes	❑ No	Rash	❑ Yes	❑ No
Allergies to Medicine	❑ Yes	❑ No	Eye Problem	❑ Yes	❑ No	Respiratory Disease	❑ Yes	❑ No
Anemia	❑ Yes	❑ No	Fainting	❑ Yes	❑ No	Rheumatic Fever	❑ Yes	❑ No
Angina	❑ Yes	❑ No	Foot or Leg Cramps	❑ Yes	❑ No	Shortness of Breath	❑ Yes	❑ No
Arthritis	❑ Yes	❑ No	Heart Disease	❑ Yes	❑ No	Sinus Problem	❑ Yes	❑ No
Artificial Heart Valves	❑ Yes	❑ No	Hemophilia	❑ Yes	❑ No	Sickle Cell Disease/Trait	❑ Yes	❑ No
Artificial Joints	❑ Yes	❑ No	Hepatitis or Jaundice	❑ Yes	❑ No	Stroke	❑ Yes	❑ No
Asthma	❑ Yes	❑ No	High Blood Pressure	❑ Yes	❑ No	Swelling in Ankles or Feet	❑ Yes	❑ No
Back pain	❑ Yes	❑ No	High Cholesterol	❑ Yes	❑ No	Tuberculosis	❑ Yes	❑ No
Bleeding Disorders	❑ Yes	❑ No	Kidney Problem	❑ Yes	❑ No	Ulcers	❑ Yes	❑ No
Cancer	❑ Yes	❑ No	Liver Disease	❑ Yes	❑ No	Varicose Veins	❑ Yes	❑ No
Chest Pain	❑ Yes	❑ No	Low Blood Pressure	❑ Yes	❑ No	Warts	❑ Yes	❑ No
Chronic Diarrhea	❑ Yes	❑ No	Nervous/Psychiatric Care	❑ Yes	❑ No	Weight Loss, unexplained	❑ Yes	❑ No
Circulatory Problem	❑ Yes	❑ No	Phlebitis	❑ Yes	❑ No	Other: ________________		
Diabetes	❑ Yes	❑ No	Prostate Problem	❑ Yes	❑ No			
Ear Problem	❑ Yes	❑ No	Radiation Treatment	❑ Yes	❑ No	________________		

Other Illnesses: ____

Surgeries you have had: ____

____

Hospitalization other than for the surgeries listed: ____

____

Your primary Medical Doctor: ______________________ Date of last visit: ______________

Immediate Family History

❑ Stroke	❑ Arthritis	❑ High Blood Pressure	❑ Other: ______________
❑ Cancer	❑ Kidney Disease	❑ Flat Feet	
❑ Diabetes	❑ Osteoporosis	❑ Seizure Disorder	______________

Medications

Include all prescriptions, over-the-counter medications and vitamins.

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____

____

____

____

____

Allergies

❑ **NO ALLERGIES**

- ❑ Adhesive/Tape
- ❑ Codeine
- ❑ Iodine
- ❑ Novocain
- ❑ Penicillin
- ❑ Seafood
- ❑ Sulfa
- ❑ Other: ______________

Consent for Procedures & Privacy Practices Acknowledgment

I certify that the above information is true and correct to the best of my Knowledge. I authorize Dr. Clements, her assistants and/or other qualified medical personnel of her choice to administer and perform such procedures as may be deemed necessary in the diagnosis and/or treatment of my podiatric medical condition. I acknowledge that I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

Patient's Signature: ______________________________ Date: ______________

Do I Need a Test for PAD?

Peripheral Arterial Disease (PAD) is a serious circulatory problem in which the blood vessels that carry blood to your arms, legs, brain or kidneys become narrowed or clogged. It affects over 8 million Americans, most over the age of 50. It may result in leg discomfort with walking, poor healing of leg sores/ulcers, difficult to control blood pressure, or symptoms of stroke. People with PAD are at significantly increased risk for stroke and heart attack. Answers to these questions will determine if you are at risk for PAD and if a vascular exam will help us better assess your vascular health status.

Name: ______________________________ Date: ______________

	Check "Yes" or "No"
1. Do you have foot, calf, buttock, hip or thigh discomfort (aching, fatigue, tingling, cramping or pain) when you walk which is relieved by rest?	☐ Yes ☐ No
2. Do you experience any pain at rest in your lower leg(s) or feet?	☐ Yes ☐ No
3. Do you experience foot or toe pain that often disturb your sleep?	☐ Yes ☐ No
4. Are your toes or feet pale, discolored, or bluish?	☐ Yes ☐ No
5. Do you have skin wounds or ulcers on your feet or toes that are slow to heal (8-12 weeks)?	☐ Yes ☐ No
6. Has your doctor ever told you that you have diminished or absent pedal (foot) pulses?	☐ Yes ☐ No
7. Have you suffered a severe injury to the leg(s) or feet?	☐ Yes ☐ No
8. Do you have an infection of the leg(s) or feet that may be gangrenous (black skin tissue)?	☐ Yes ☐ No
9. Have you ever smoked?	☐ Yes ☐ No
10. Have you previously had a stroke?	☐ Yes ☐ No
11. Do you have heart disease?	☐ Yes ☐ No

Patient Signature: ____

Physician Signature: ______________________ Date: ______________

FLAT SHOALS FOOT AND ANKLE CENTER

2855 Candler Road Suite 10

Decatur, GA 30034-1415

SUZETTE CLEMENTS, D.P.M

ANILA RAFIQ, D.P.M

PLEASE INITIAL AT THE BEGINNING OF EACH SENTENCE AFTER READING IT. PLEASE LET ME KNOW IF YOU HAVE ANY QUESTIONS.

____ I have read and agree to the afore mentioned referral process. I understand that it is my responsibility to obtain the referral if one is needed.

____ I understand that I am responsible for all copays, deductibles, co-insurance and any charges not covered by my insurance company.

___ I have read and agree with the Medicare authorization policy.

____ I acknowledge that I have read and was offered a copy of the Notice of Privacy Practice and understand the Notice.

_____ I understand that there is a $25.00 no show fee. If I do not cancel my appointment in 24 hours.

Pharmacy Name: ______________________________ Phone Number: ____________

I give permission for the following to be given information about appointments, test results, or discuss financial responsibility:

Name: __________________________ Relation: ____________________ Number: __________

Name: __________________________ Relation: ____________________ Number: ___________

Signature: ____ Date: ____________

Office Staff: ____ Date: ____________