Medical History & Patient Information

Name: First _____ MI___ Last_____

Home Address: _____**APT#**_____

City: _____ **State**: _____ **Zip Code**: _____

Date of Birth: _____ Age: _____ Height: _____ Weight: _____lbs

Home Phone: _____ Work Phone: _____

Cell Phone: _____ Sex: M / F Marital Status: S M D Sep W

E-Mail: _____Social Security #: _____

Please check any method(s) we can contact you:

Phone_____ Email _____ Text_____ Does Not matter_____

Race: Asian
Black or African American
White
American Indian or Alaska Native
Native Hawaiian or Other Pacific Islander
Not specified

Ethnicity: Hispanic or Latino Not Hispanic or Latino Not specified

Preferred language: _____

Patient's Employer: _____ Occupation: _____

Type of work: Sedentary, some sitting/some standing, on feet all day, manual labor **(circle one)**

Are You A Student? Yes or No Grade: _____ **(circle one)**

Emergency Contact's Name: _____

Phone Number: _____

Pharmacy Name: _____ Phone: _____

Address/Location: _____ City: _____

How did you hear about us?_____

INSURANCE INFORMATION

If you have a digital copy of your insurance card please email it to Stephanie@Landmarkfootandankle.com

Insurance Company Name: _____

□ *Please check here if you, the patient listed above, are the main policy holder*

Policy Holders Name:_____ Birthday_____

SSN#: _____ Relationship to Patient: Parent: ___Spouse: ____Other:_____

Primary Doctor: _____ Date last seen: _____

If Diabetic, who is your treating Physician: _____

Date last seen: _____ Hemoglobin A1c (most recent lab result): _____

On the diagram to the right, please circle the areas of pain or problem(s).

Describe your foot or ankle problem? _____

_____

_____

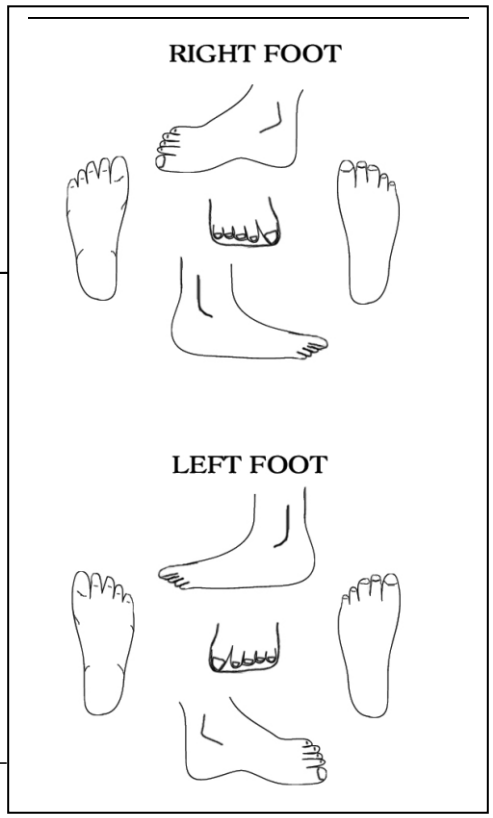
How long has this been bothering you?

_____

What has been done to treat this?

_____

_____



Social History

Do you smoke? Yes/No Amount/day: _____ #Years: _____
Do you drink alcohol? Yes/No #drinks/how often: _____
Do you use any recreational drugs? Yes/No Type: _____

DRUG Allergies: _____

_____

_____

Medications

Please list all current medications (with dosage). Include over-the-counter, vitamins, herbal supplements.

Name of Medication	Dosage/Frequency	Reason for taking medicine

Next

Personal Medical History and Review of Systems (Please check all that apply)

Eyes, Ears, Nose & Throat:

__ Impaired sight __Cataracts __Frequent Nose bleeds
__ Glaucoma __ Hearing loss __Retinopathy

Respiratory:

__ Chronic Bronchitis __ Asthma __Pulmonary Embolus __Lung Cancer
__ Tuberculosis __ Emphysema __ Allergies __ C.O.P.D.

Cardiovascular:

__Heart attack __Deep Vein Thrombosis __ High blood pressure __Heart Failure
__Angina __Venous Insufficiency __High cholesterol __Mitral valve prolapse
__Arrhythmia __Peripheral Vascular Disease __Abdominal Aneurysm __Vasculitis
__Coronary Artery Disease __Intermittent Claudication __Fainting Spells __Pacemaker

Gastrointestinal:

__ Peptic ulcer __Liver Cancer __Stomach Cancer __Reflux esophagitis/GERD
__ Gallbladder problem __Colon Cancer __Pancreatic Cancer __Diverticulosis
__ Hepatitis A __ Hepatitis B __ Hepatitis C __ Cirrhosis
__ Diarrhea __ Crohn's/colitis

Bladder, Kidney:

__ Frequent urination __ Bladder infections __ Kidney stone
__ Renal failure __Bladder Cancer __Kidney Cancer

Female:

__ Breast cancer __ Ovarian cancer

Male:

__Benign Prostatic Hypertrophy __Prostate cancer

Hematologic (Blood Disorders):

__ Anemia __Sickle cell disease/trait __Bleeding disorder __Leukemia
__Lymphoma __Platelet disorder

Endocrine:

__ Diabetes: Type 1 or Type 2 __Hypothyroidism __Hyperthyroidism

Neurological (Nervous System):

__ Seizures __ Parkinson's __ Migraines __ Stroke/TIA
__Alzheimer's __ Ataxia __ Multiple Sclerosis __ Sciatica
__ Neuropathy __ Muscular Dystrophy __ Polio __Degenerative Disc Disease
__Charcot-Marie Tooth Disease __Cerebral Palsy __Brain Tumor

Bone and Joint:

__Rheumatoid Arthritis __Reiter's Disease __ Gout __ Osteoporosis
__Osteoarthritis __Ankylosing Spondylitis __Charcot Joint __Bone or muscle Cancer
__Lupus __Osteomyelitis __Psoriatic Arthritis __Paget's
__Fractures: Type/Location_____

Skin:

__Lichen Planus __ Rosacea __ Psoriasis __ Eczema
__Basal Cell Carcinoma __Squamous Cell Carcinoma __Melanoma __Hypertrophic scars/Keloid

Psychiatric:

__Insomnia __ Depression __ Anxiety __Bi-Polar Disorder

Childhood Illnesses:

__Rheumatic Fever __ Chicken pox __ Mumps

Immunology:

__ HIV __Neutropenic __ Chronic fatigue syndrome

Surgeries and Hospitalizations

Previous Surgeries/Hospitalizations	Approximate Dates	Reason

Family History (Please mark all that apply with a M-Mother and/or F-Father)

Arthritis:_____ Cancer_____ Type: _____ Diabetes Circle (Type 1 or 2) _____
Epilepsy: _____ Foot problems:_____ Type:_____
Heart disease: _____ High Blood Pressure:_____ High cholesterol:_____
Stroke: _____ Other:_____

Any other pertinent information that you would like the doctor to know:

_____
_____
_____
_____

LANDMARK FOOT & ANKLE CENTER, P.C.

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OFFICE POLICY

We would like to welcome you to our office. We strive to provide top quality care in a comfortable atmosphere. We submit claims to your primary, secondary and tertiary insurances. We have found, however, that few insurance plans cover the entire cost involved in your visit(s). **Your policy is between you and your insurance company and it is important that you understand its provisions**. **We cannot guarantee payment of your claims or accept responsibility for negotiating your claim. At this time, we are not accepting state issued health plans from any new patients (e.g. Medicaid, Anthem Healthkeepers Plus, Famis, Amerigroup, (Aetna Leap plans, only Dr Kim), Community Care Plans, etc).**

Co-payments are due at the time of your visit; if you do not pay you co-pay on the date of service an administration fee of $10 will be added. Please note that you will be required to pay the bill in full if you are a ***SELF-PAY*** patient. We accept cash, checks, all major credit cards and money orders for payments.

If your insurance company requires a referral to be seen by Landmark Foot and Ankle Center, you are responsible for providing this to us the day of your appointment. **If you do not have a valid referral you will need to reschedule your appointment.**

It is the responsibility of the patient to inform us of ANY address changes or insurance changes. *(Note: If your insurance changes and we need to re-bill any claims out under your new policy you will be charged a $10 fee).*

At the beginning of each month, a billing statement will be sent to you, informing you of your account status. Any returned checks will incur a fee of $35.00 plus any bank fees associated with the returned check. **Any account overdue after 90 days will be turned over to collections**. *Any attorney fees, court costs, and all fees involved with the collection process are the sole responsibility of the patient. Be aware that 33 1/3% will automatically be assessed at the time the account is sent to collections.*

It is important that you cancel any office appointment at least 24 hrs in advance, so that we can utilize that appointment time for emergencies if need be. If you fail to cancel within 24 hrs or you do not show up to your appointment, you will be charged a fee of $35.00. If you are scheduled for surgery and cancel within seven business days, you will be charged $100.00. If you do not show up for any scheduled surgery, you will be charged $250.00. This charge is not reimbursable by your insurance company and is your sole responsibility.

Due to increasing administrative and personnel costs, we will be charging for the following: ***Medical records***: 1-20 pages $20.00; $1.00 each additional page, ***X-Rays***: $20.00 per set of x-rays, ***Disability, Work or Medical forms***: $20.00. Please allow up to **7 business days** for your request to be completed.

I understand that my doctor will explain the risks, benefits, and alternative treatments, before any treatment(s) are rendered. These may include surgical procedure(s), diagnostic test(s) and medical care. I authorize my physician to perform such procedures after we have discussed these, which are advisable in their professional judgment.

I, the patient or representative, authorizes Landmark Foot & Ankle Center, P.C. to apply for benefits on my behalf for covered services rendered by Landmark Foot & Ankle Center, P.C. I request that the payments from my providing insurance company be made directly to Landmark Foot & Ankle Center, P.C. I understand that I am responsible and I agree to promptly pay all charges for medical services at the time services are rendered and accept legal responsibility for any and all charges for myself or the patient, including all costs incurred by our collection attorney. I understand that I am responsible for all professional fees and charges regardless of insurance coverage or any other source of payment.

I certify that the information I have reported, with regard to my insurance coverage, is correct. I further authorize the release of any necessary information, including medical information for this or any related claim, to the above named billing agent. I permit a copy of this authorization to be used in place of the original. This authorization may be revoked by either the above named carrier or myself at any time in writing.

_____ _____ _____

Signature | Relationship to patient | Date

“NOTICE OF PRIVACY PRACTICES”

Acknowledgment of Receipt

By signing this page, I acknowledge having received the HIPAA notice from Landmark Foot & Ankle Center, PC that describes how medical information about me may be used and disclosed.

- Patient Name: _____
- Signature: _____

Relationship to Patient: _____

- Date: _____

Witness: _____