FAMILY FOOT & ANKLE CLINICS OF WI

6123 Green Bay RD, Suite 100A Kenosha, WI 53142
5802 Washington Ave, Suite 202 Racine, WI 53406

Patient Information (Please use full legal name, no nicknames please)		
Last Name:	First Name:	Middle Name:
Date of Birth:	SSN:	Gender: □ Male □ Female
Address:		
City:	State:	Zip Code:
Home Phone: ( )	Cell Phone: ( )	Work Phone: ( )
Preferred Phone: □ Home □ Cell □ Work	**Email:**	
Race/Ethnicity: □ American Indian/Alaska Native □ Asian □ Black/African American □ Hispanic/Latino		
□ More Than One Race □ Native Hawaiian □ Pacific Islander □ White/Caucasian □ Choose Not to Report		
Marital Status: □ Single □ Married □ Separated □ Divorced □ Widowed		
Height: Weight:	Shoe Size:	Student: □ Yes □ No Full or Part Time
Employer:		
Address:		
City:	State:	Zip Code:
Emergency Contact Name:	Relationship:	
Emergency Contact Phone: ( )		
PHARMACY (include STREET and PHONE NUMBER):		
**If Minor Patient Only: (Please use full legal name, no nicknames please)*		
Person Responsible for Bill: □ Mother □ Father	**Marital Status**: □ Single □ Married □ Separated □ Divorced	
Mother's First & Last Name:	DOB:	SSN:
Father's First & Last Name:	DOB:	SSN:
Address (if different from above):		
Insurance Information (Please allow receptionist to photocopy your insurance ID cards)		
Primary Insurance Name:	Member ID:	Group #:
Policy Holder's (PH) Name:	PH DOB:	PH SSN:
Insurance Claims Address & Phone:		
Secondary Insurance Name:	Member ID:	Group #:
Policy Holder's (PH)Name:	PH DOB:	PH SSN:
Insurance Claims Address & Phone:		

How Did You Hear About Our Office? ☐
Doctor: _____

☐ Friend ☐ ER ☐ Family ☐ Insurance Company ☐ Hospital ☐ Internet ☐ Other: _____

Prior Medical History Information

Allergies or Adverse Reactions: □ **No Known Drug Allergies**

□ Aspirin □ Codeine □ Cortisone □ Iodine/Shellfish □ Sulfa □ Tape □ Penicillin □ Latex □ Local Anesthetics: □ Other, please list:

Major Disease:		***Cardiovascular:***		***Foot Problems:***	
Cancer	□ Self □ Family	Anemia	□ Self □ Family	Ankle Pain	□ Self □ Family
Diabetes □Type 1 □Type 2	□ Self □ Family	Bleeding Disorder	□ Self □ Family	Bunion	□ Self □ Family
Blood Pressure □ High □ Low	□ Self □ Family	Peripheral Vascular Disease	□ Self □ Family	Corns/Callouses	□ Self □ Family
Angina	□ Self □ Family	Poor Circulation	□ Self □ Family	Flat Feet	□ Self □ Family
Heart Disease	□ Self □ Family	Phlebitis	□ Self □ Family	Heel Pain	□ Self □ Family
Heart Attack	□ Self □ Family	Anticoagulation Therapy	□ Self □ Family	Ingrown Toenail	□ Self □ Family
Aids/HIV	□ Self □ Family	DVT/Blood Clots	□ Self □ Family	Plantar Warts	□ Self □ Family
Stroke	□ Self □ Family	Other:	□ Self □ Family	Plantar Fasciitis	□ Self □ Family
Other:	□ Self □ Family	***Musculo-Skeletal:***		Athlete's Foot	□ Self □ Family
Nervous:		Arthritis	□ Self □ Family	Tired Feet	□ Self □ Family
Numbness	□ Self □ Family	Joint Disease	□ Self □ Family	Other:	□ Self □ Family
Headaches	□ Self □ Family	Gout	□ Self □ Family	***Respiratory:***	
Seizure / Convulsion	□ Self □ Family	Fibromyalgia	□ Self □ Family	Asthma	□ Self □ Family
Paralysis	□ Self □ Family	Sciatica	□ Self □ Family	Bronchitis	□ Self □ Family
Loss of Feeling	□ Self □ Family	Other:	□ Self □ Family	COPD	□ Self □ Family
Depression	□ Self □ Family	***HEENT:***	□ Self □ Family	Emphysema	□ Self □ Family
Anxiety	□ Self □ Family	Hearing Problems	□ Self □ Family	Short of Breath	□ Self □ Family
Aneurysm	□ Self □ Family	Eye Problems	□ Self □ Family	Lung Disease	□ Self □ Family
Autism	□ Self □ Family	Ear Problems	□ Self □ Family	Tuberculosis	□ Self □ Family
Other:	□ Self □ Family	Other:	□ Self □ Family	Other:	□ Self □ Family

Primary Care Physician

Primary Care Physician Name: Exact Date Last Seen:

Primary Care Physician Address: Phone:( )

Did your Primary Care Physician or Other Specialist Refer You? □ Yes □ No

Are You Currently Under the Care of Any Other Specialists? □ Yes □ No

Specialist Physicians

Name:	Specialty:	Condition Currently under care:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

OTHER MEDICAL INFORMATION:

SOCIAL HISTORY

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

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

DO OTHERS DEPEND UPON YOU FOR THEIR CARE? ☐ CHILDREN–AGE(S) _____ ☐ PET(S)–WHAT KIND? _____
☐ ELDERLY OR DISABLED FAMILY MEMBER ☐ OTHER _____

EXERCISE: ☐ NEVER ☐ RARE ☐ OCCASIONAL ☐ WEEKLY ☐ SEVERAL TIMES A WEEK ☐ DAILY

TYPES OF EXERCISE: _____

PLEASE LIST ALL PRIOR SURGERIES:

TYPE OF SURGERY	DATE	TYPE OF SURGERY	DATE

PLEASE LIST ALL PRIOR HOSPITALIZATIONS (OTHER THAN FOR SURGERY):

REASON FOR HOSPITALIZATION	DATE	REASON FOR HOSPITALIZATION	DATE

RECENT MEDICAL TESTING (IN THE LAST 6 MONTHS):

CURRENT PROBLEM

WHAT SPECIFIC PROBLEM BRINGS YOU TO OUR OFFICE TODAY?

_____

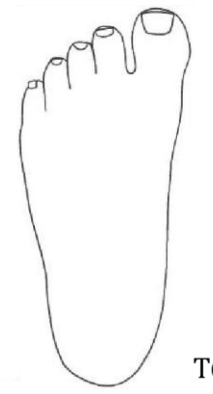
_____

_____

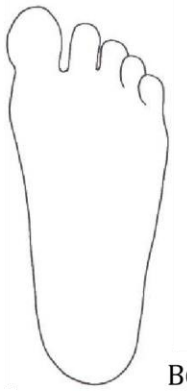
_____

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

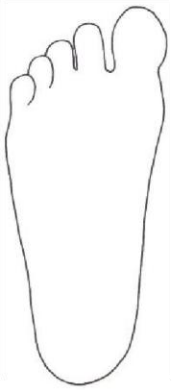
LEFT FOOT



TOP OF FOOT

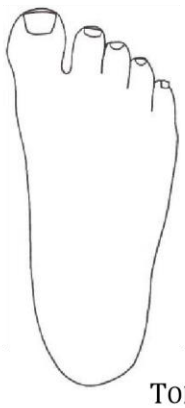


BOTTOM OF FOOT

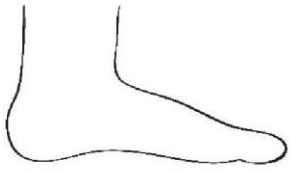


BOTTOM OF FOOT

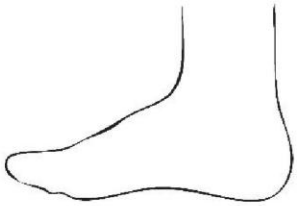
RIGHT FOOT



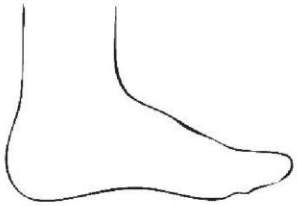
TOP OF FOOT



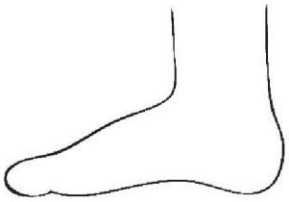
INSIDE OF FOOT



OUTSIDE OF FOOT



OUTSIDE OF FOOT



INSIDE OF FOOT

HOW LONG AGO DID THIS PROBLEM FIRST START? _____ DAYS / WEEKS / MONTHS / YEARS

DID YOUR PAIN OR PROBLEM: ☐ BEGIN ALL OF A SUDDEN ☐ GRADUALLY DEVELOP 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) 0 1 2 3 4 5 6 7 8 9 10 *(WORST PAIN POSSIBLE)*

SINCE THE TIME YOUR PAIN OR PROBLEM BEGAN, HAS IT: ☐ STAYED THE SAME ☐ BECOME WORSE ☐ IMPROVED

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

WHAT MAKES YOUR PAIN OR PROBLEM FEEL BETTER? _____

WHAT TREATMENTS HAVE YOU HAD FOR THIS PROBLEM? _____

HOW HAS THIS PROBLEM AFFECTED YOUR LIFESTYLE OR ABILITY TO WORK? _____

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

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

Medication Log (Please include supplements and over the counter medications)				
Patient Name:				
Medication	Dose/MG	Frequency	Condition	Prescriber

Request for Confidential Communications

I request that all confidential communication to me from Dr. William Yoder and staff at Family Foot & Ankle Clinics of WI be handled in the following manner: **Check all that apply.**

Written Communication:

□ to my home address
□ to a different address: _____
□ to my email address: _____

Telephone Communication:

□ Home number
□ Cell phone
□ Different number: _____ □
With family member:

_____

□ Answering machine/voicemail **Test Results:**

□ May only release test results to myself
□ May leave with results with spouse, other family member, or answering machine/voicemail

I certify that the above information is true and correct to the best of my knowledge. I hereby give permission for Family Foot & Ankle Clinics of WI to administer and perform such procedures as may be deemed necessary in diagnosis/treatment of my feet/ankles. I authorize the release of any information to my insurance company and any medial information necessary to process any claim and I request payment of insurance benefits due to Family Foot & Ankle Clinics of WI to be paid directly to Family Foot & Ankle Clinics of WI.

I hereby give my permission for Family Foot & Ankle Clinics of WI to forward any pertinent medical information to my primary or referring physician for continuity of care. I permit a copy of this authorization to be used in place of the original. This authorization may be revoked at any time by either myself or my insurance company in writing. The above information is true and I will notify Family Foot & Ankle Clinics of WI of any changes.

Signature of Patient, Parent, or Legal Guardian: _____Date: _____

Printed name of Patient, Parent, or Legal Guardian: _____

Relation to patient: _____

Patient Contract

Payment is expected at time of service. EXCEPTIONS to include: Medicare patients, PPO and HMO/POS members.
As a courtesy, we will be happy to bill your primary and secondary insurance company on your behalf. It is up to each patient to know the rules and limitations of your policies.
If your insurance company does not make the payment you expect, it is up to the policyholder to contact the insurance company. Our office will supply any documentation necessary to expedite the handling of the claim.
Any balance past 90 days in considered delinquent, and will be put to patient responsibility. It is your responsibility to contact your insurance company if payment is delayed. Most insurance companies DO NOT COVER SUPPLIES given in an office setting; payment will be due at the time of service for such supplies (ABN SIGNAUTURE WILL BE REQUIRED). We will attempt to bill these supplies to your insurance company and refund any money received to you.
If you need to cancel an appointment, please notify us at least 24 hours in advance. We will gladly reschedule your appointment.

Financial Policy

We are committed to providing you with the best possible care and are pleased to discuss our professional fees with you at any time. Your clear understanding of our Financial Policy is important to our professional relationship. Please ask if you have any questions about our fees, financial policy, or your financial responsibility.

FOR BILLING PURPOSES: it is the patient's responsibility to update any changes such as Address, phone, and insurance company.

COPAYMENTS: By law we must collect your carrier designated copay at the time of service.

COINSURANCE/DEDUCTIBLE: are patient responsibility. A billing statement will reflect such charged deemed patient responsibility.

REFERRALS: if your insurance policy requires a referral from your PCP, it is your responsibly to obtain it prior to your appointment. If you do not obtain a referral, you will be responsible for all charges.

SELF PAY PATIENTS (NO INSURANCE): Payment is REQUIRED at the time of service.

MEDICARE: We will submit to Medicare for the entire Medicare allowed amount. The patient will be responsible to the deductible and the 20% co-insurance, which can be billed directly to secondary insurance if applicable.

DELIQUENT ACCOUNT: Any account after 90 days with no payment. After 90 days will be sent to 3rd party collection agency with late fees.

LATE FEES: Patient will be charged a late fee for non-payment if your account has been transferred to a 3rd party collection company. Fees will reflect cost accessed from 3rd party collection company and time taken processing account.

WE ACCEPT CASH, CHECK, MASTERCARD, VISA, and DISCOVER.

Acknowledgement of Receipt of Notice of Privacy Practice

I acknowledge that I was provided/offered a copy of the Notice of Privacy Practices from Family Foot & Ankle Clinics of WI and that I have read (or had the opportunity if I so chose) and understand the notice.

I have read & understand the above Patient Contract & Financial Policy/Confidential Communications for Family Foot & Ankle Clinics

Signature of Patient, Parent, or Legal Guardian: _____Date: _____

Printed name of Patient, Parent, or Legal Guardian: _____

Relation to patient:_____