

FAMILY FOOT & ANKLE CLINICS OF WI

3535 30th Ave, Suite 203 Kenosha, WI 53144
5802 Washington Ave, Suite 202 Racine, WI 53406

<i>Patient Information (Please use full legal name, no nicknames please)</i>		
Last Name:	First Name:	Middle Name:
Date of Birth:	SSN:	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female
Address:		
City:	State:	Zip Code:
Home Phone: ()	Cell Phone: ()	Work Phone: ()
Preferred Phone: <input type="checkbox"/> Home <input type="checkbox"/> Cell <input type="checkbox"/> Work Email:		
Race/Ethnicity: <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black/African American <input type="checkbox"/> Hispanic/Latino		
<input type="checkbox"/> More Than One Race <input type="checkbox"/> Native Hawaiian <input type="checkbox"/> Pacific Islander <input type="checkbox"/> White/Caucasian <input type="checkbox"/> Choose Not to Report		
Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed		
Height:	Weight:	Shoe Size: Student: <input type="checkbox"/> Yes <input type="checkbox"/> No Full or Part Time
Employer:		
Address:		
City:	State:	Zip Code:
Emergency Contact Name:		Relationship:
Emergency Contact Phone: ()		
PHARMACY (include STREET and PHONE NUMBER):		
<i>*If <u>Minor</u> Patient Only: (Please use full legal name, no nicknames please)</i>		
Person Responsible for Bill: <input type="checkbox"/> Mother <input type="checkbox"/> Father		Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced
Mother's First & Last Name:	DOB:	SSN:
Father's First & Last Name:	DOB:	SSN:
Address (if different from above):		
<i>Insurance Information (Please allow receptionist to photocopy your insurance ID cards)</i>		
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?		
<input type="checkbox"/> Doctor: _____		
<input type="checkbox"/> Friend <input type="checkbox"/> ER <input type="checkbox"/> Family <input type="checkbox"/> Insurance Company <input type="checkbox"/> Hospital <input type="checkbox"/> Internet <input type="checkbox"/> 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	<input type="checkbox"/> Self <input type="checkbox"/> Family	Anemia	<input type="checkbox"/> Self <input type="checkbox"/> Family	Ankle Pain	<input type="checkbox"/> Self <input type="checkbox"/> Family
Diabetes	<input type="checkbox"/> Self <input type="checkbox"/> Family	Bleeding Disorder	<input type="checkbox"/> Self <input type="checkbox"/> Family	Bunion	<input type="checkbox"/> Self <input type="checkbox"/> Family
H/L Blood Pressure	<input type="checkbox"/> Self <input type="checkbox"/> Family	Peripheral Vascular Disease	<input type="checkbox"/> Self <input type="checkbox"/> Family	Corns/Callouses	<input type="checkbox"/> Self <input type="checkbox"/> Family
Angina	<input type="checkbox"/> Self <input type="checkbox"/> Family	Poor Circulation	<input type="checkbox"/> Self <input type="checkbox"/> Family	Flat Feet	<input type="checkbox"/> Self <input type="checkbox"/> Family
Heart Disease	<input type="checkbox"/> Self <input type="checkbox"/> Family	Phlebitis	<input type="checkbox"/> Self <input type="checkbox"/> Family	Heel Pain	<input type="checkbox"/> Self <input type="checkbox"/> Family
Heart Attack	<input type="checkbox"/> Self <input type="checkbox"/> Family	Anticoagulation Therapy	<input type="checkbox"/> Self <input type="checkbox"/> Family	Ingrown Toenail	<input type="checkbox"/> Self <input type="checkbox"/> Family
Aids/HIV	<input type="checkbox"/> Self <input type="checkbox"/> Family	DVT/Blood Clots	<input type="checkbox"/> Self <input type="checkbox"/> Family	Plantar Warts	<input type="checkbox"/> Self <input type="checkbox"/> Family
Stroke	<input type="checkbox"/> Self <input type="checkbox"/> Family	Other:	<input type="checkbox"/> Self <input type="checkbox"/> Family	Plantar Fasciitis	<input type="checkbox"/> Self <input type="checkbox"/> Family
Other:	<input type="checkbox"/> Self <input type="checkbox"/> Family	Musculo-Skeletal:		Athlete's Foot	<input type="checkbox"/> Self <input type="checkbox"/> Family
Nervous:		Arthritis	<input type="checkbox"/> Self <input type="checkbox"/> Family	Tired Feet	<input type="checkbox"/> Self <input type="checkbox"/> Family
Numbness	<input type="checkbox"/> Self <input type="checkbox"/> Family	Joint Disease	<input type="checkbox"/> Self <input type="checkbox"/> Family	Other:	<input type="checkbox"/> Self <input type="checkbox"/> Family
Headaches	<input type="checkbox"/> Self <input type="checkbox"/> Family	Gout	<input type="checkbox"/> Self <input type="checkbox"/> Family	Respiratory:	
Seizure / Convulsion	<input type="checkbox"/> Self <input type="checkbox"/> Family	Fibromyalgia	<input type="checkbox"/> Self <input type="checkbox"/> Family	Asthma	<input type="checkbox"/> Self <input type="checkbox"/> Family
Paralysis	<input type="checkbox"/> Self <input type="checkbox"/> Family	Sciatica	<input type="checkbox"/> Self <input type="checkbox"/> Family	Bronchitis	<input type="checkbox"/> Self <input type="checkbox"/> Family
Loss of Feeling	<input type="checkbox"/> Self <input type="checkbox"/> Family	Other:	<input type="checkbox"/> Self <input type="checkbox"/> Family	COPD	<input type="checkbox"/> Self <input type="checkbox"/> Family
Depression	<input type="checkbox"/> Self <input type="checkbox"/> Family	HEENT:	<input type="checkbox"/> Self <input type="checkbox"/> Family	Emphysema	<input type="checkbox"/> Self <input type="checkbox"/> Family
Anxiety	<input type="checkbox"/> Self <input type="checkbox"/> Family	Hearing Problems	<input type="checkbox"/> Self <input type="checkbox"/> Family	Short of Breath	<input type="checkbox"/> Self <input type="checkbox"/> Family
Aneurysm	<input type="checkbox"/> Self <input type="checkbox"/> Family	Eye Problems	<input type="checkbox"/> Self <input type="checkbox"/> Family	Lung Disease	<input type="checkbox"/> Self <input type="checkbox"/> Family
Autism	<input type="checkbox"/> Self <input type="checkbox"/> Family	Ear Problems	<input type="checkbox"/> Self <input type="checkbox"/> Family	Tuberculosis	<input type="checkbox"/> Self <input type="checkbox"/> Family
Other:	<input type="checkbox"/> Self <input type="checkbox"/> Family	Other:	<input type="checkbox"/> Self <input type="checkbox"/> Family	Other:	<input type="checkbox"/> Self <input type="checkbox"/> Family

Social History: Do you smoke? Yes No Do you drink? Yes No

Surgeries: (List Procedure and Year)

Please describe the condition for which you are being seen today:

When did this problem begin? Have you seen a doctor for this? If yes, who:

How have you treated it so far?

Is this condition due to an injury? If so, when?

Primary Care Physician/Other Specialist Information

Primary Care Physician Name: 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

If Yes, Please List:

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:

Date:

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

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 is 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 SIGNATURE 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 responsibility 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.

DELINQUENT 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 assessed 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:** _____