CRIGLER FOOT & ANKLE

PATIENT INFORMATION SHEET

Patient's First Name	**Middle Initial**	**Last Name**
Address		
Date of Birth	**Age**	**Social Security Number**
Emergency Contact Information	**Phone**	
Patient: Home Phone	**Cell Phone**	**E-Mail** / **Work Phone**
Employer		
Guarantor's Name and Address (If patient is a minor)		
Guarantor's Social Security	**Guarantor's Relationship to Patient**	
Primary Insurance Company Name and Address		
Primary Subscriber Name	**Primary Subscriber Social Security Number'**	
Policy Number	**Group Number**	
Secondary Insurance Company Address		
Primary Subscriber Name	**Primary Subscriber Social Security Number'**	
Policy Number	**Group Number**	
Patient's Primary Care Physician Name and Address	**Primary Care Physician Telephone**	
Patient's Pharmacy Name and Address	**Pharmacy Telephone**	
Reason for Today's Visit		

I hereby give Crigler Foot & Ankle permission to examine and treat me. I also authorize the release of any medical information necessary to process my claims. I hereby request payment of any insurance or 3rd party benefits that I am entitled to, be made directly to Crigler Foot & Ankle for any services rendered to me during the course of my treatment.

____ ____________________

Patient Signature or Guardian if Minor **Date**

History and Medical Information Sheet

Patient:_________________________

1. Explain your foot/ankle problems. Circle which foot Right Left Both

____

____

1. When did the pain/discomfort begin: ____
2. Describe the pain/discomfort (Circle) Burning Numbness Sharp Other
3. What makes the pain/ discomfort better ____
4. What makes the pain discomfort worse ____
5. Has the condition been treated in the past and what was done:

____

____

6. List all medications you are on including natural herbs:

____

____

7. Have you had any previous surgeries? If yes please describe:

____

____

8. Job Title: _______________________ Job requirements % Standing____ %Sitting____%Lifting__

Social History: Please check those that apply and describe how often:

❑Tobacco Use______________ ❑ Caffeine Use ______________ ❑Exercise________________

❑Alcohol Use ______________ ❑Drug Use____

Past Medical History: Please check those which apply

❑Anemia ❑Hepatitis ❑Coronary Artery Disease/Heart attack ❑Bleeding Disorder

❑HIV/Aids ❑Sleep Apnea ❑Mitral Valve Prolapse ❑Ulcer

❑Arthritis ❑Cancer ❑Brain/Neurological Disorder ❑Diabetes

❑Epilepsy ❑Asthma ❑Esophageal Disorder ❑Thyroid Disorder

❑Stroke ❑Tuberculosis ❑Lung/Respiratory Disorder ❑Gout

❑Heart Murmur ❑High Blood Pressure ❑Prostate Disorder

❑High Cholesterol ❑Heart Failure ❑Nerve Disorder

❑Other____

Allergies: Please list all and reaction

____

____

Family History: Please list conditions of family

____

I would like to receive automated appointment reminders via (may select more than one)

❑Voice ❑Text ❑ Email ❑I would not like to receive automated reminders

*Standard messaging and data rates may apply

Financial Policy

Thank you for choosing Crigler Foot & Ankle. We are committed to providing you with the highest quality podiatric care. If you have health insurance, we would like to help you receive your maximum covered benefits. The following information is provided to help you understand this process and alleviate any misunderstandings that may occur concerning payment for professional services rendered.

- We must have accurate information from you every time you visit the office in order to process your claim correctly.
- Some services may not be covered by your insurance company as there are many different plans available and not all plans cover all services. It is important that you become familiar with your plan and the coverage available to you.
- We believe that the choice for medical treatment should be yours. Should you choose to receive treatment at our office for any service or product not covered by your insurance company, you agree to be responsible for the payment of these charges.
- You are responsible for any deductible, co-insurance and/or co-payment as stated in your plan. These payments are due at the time of service.
- In most cases, we will accept assignment of insurance benefits. What we charge is usual and customary for our area. You are responsible for full payment regardless of any insurance company's arbitrary determination of usual and customary rates. Estimated deductibles and co-payments are due at the time of service.
- By law, your insurance company must remit payment or deny your claim within 30 days of the initial notice of claim. We may need you to assist us in contacting your insurance company to resolve any insurance issue.

The fee to copy medical records is $1.00 per photocopied page and $10 per x-ray film duplication. We understand that temporary financial problems may affect the timely payment of your account. If such problems arise, please contact our office at (407) 331-3668 for assistance in the management of your account. I have read and understand this financial policy of Crigler Foot & Ankle and agree to all the terms and conditions described in it.

Patient Signature_____________________________________ Date_________________

Patient Name Printed____

Privacy Policy

Patient Name:_______________________________________Date:_________________

I hereby authorize the release or use of my individually identifiable health information ("protected health information") and medical record information by Crigler Foot and Ankle, in order to carry out treatment, payment of health care operations. You should review the practice's Notice of Privacy Practices for a more complete description of the potential release and use of such information. You have the rights to review such notices prior to signing this consent form.

If you allow a third party other than one of our staff to be in the exam room while our physician or staff is examining you or discussing your care, treatment or medical condition with you, by signing this consent form, you are consenting to the disclosure of our protected health information to that party.

The practice reserves the right to change the terms of its Notice of Privacy Practice at any time. If we do make changes to the terms of the Notice of Privacy Practices, you may obtain a copy of the revised notice.

You retain the right to request that we further restrict how your protected health information is released or used to carry out our treatment, payment or health care operations. Our practice is not required to agree to such requested restrictions: however if we do agree to your restrictions, such restrictions are then binding on the practice.

Patient Signature:____

I will allow the practice to disclose my protected health and medical record information to the following:

Name______________________________________Relationship_______________________

Name______________________________________Relationship_______________________

I agree to the practice releasing information to me in the following manner(please initial)

___Mail ____Phone Voicemail ____Email ____Fax