Wilde Foot & Ankle Clinic - 407 E Centennial Dr Pittsburg, KS 66762

Patient Information

Patient Name First _____ Middle initial _____ Last _____

Nickname _____ Social Security # _____ Date of birth _____

Address _____ City _____ Phone # _____

State _____ Zip code _____ email _____

Sex assigned at birth? ___ Male ___ Female ___Unknown

Marital Status ___Single ___Married ___Partnered ___Separated ___Widow ___Divorced

Emergency Contact _____ Phone # _____

Primary Physician _____Date Last Seen _____

Employer _____ Work phone _____

Responsible Party (Who to send the bill to)

Name First _____ Middle initial _____ Last _____

Address _____ City _____ State _____ Zip code _____

Social Security # _____ Date of birth _____ Phone # _____

Employer _____ Work phone _____

Employer's address _____

Insurance Information

Primary Insurance _____ Payor ID _____

Name of Policy Holder_____ ID#_____

Relationship ___ Self ___Spouse ___Dependent ___Other Group# _____

Social Security # _____ Date of birth _____ Phone # _____

Address _____ City _____ State _____ Zip code _____

Secondary Insurance _____ Payor ID _____

Name of Policy Holder_____ ID#_____

Relationship ___ Self ___Spouse ___Dependent ___Other Group# _____

Social Security # _____ Date of birth _____ Phone # _____

Address _____ City _____ State _____ Zip code _____

Medical History

Patient Name:_____**Date:**_____

Explain your foot/ankle problem ☐ Right ☐ Left _____

_____

Accident Date _____ Is the problem work related? ☐ Yes ☐ No

Surgical History: Have you had surgery? ☐ Yes—if yes, describe below ☐ No

Surgery / Date: _____

_____

Social History: (Only check what is pertinent to you)

☐ Tobacco Use - How much? _____ ☐ Alcohol Use- How much? _____

Height _____Weight _____

Family History: (List relationship of family member(s) who have had these problems):

☐ Diabetes _____ ☐ Heart Disease _____ ☐ Rheumatology _____

☐ Hypertension _____ ☐ Stroke _____ ☐ Cancer _____

☐ Other Family History: _____

Personal Medical Hx:	☐ Gout	☐ Muscle Disorders	☐ Stomach Conditions
☐ Arthritis	☐ Heart Problems	☐ Nerve Disorders	☐ Thyroid Disorders
☐ Bleeding Disorders	☐ Hepatitis	☐ Obesity	☐ Vascular Disease
☐ Cancer _____	☐ Hyperlipidemia	☐ Respiratory Conditions	☐ _____
☐ Depression/Anxiety	☐ Hypertension	☐ Skin Conditions	☐ _____
☐ Diabetes	☐ Kidney Disease	☐ Stroke	☐ _____

List all medications/herbs/vitamins: ☐ NONE _____

_____

Allergies: ☐ NONE **List the reaction to the allergen.**

☐ Penicillin_____ ☐ Sulfa Drugs_____ ☐ Betadine/Iodine_____

☐ Contrast Dye _____ ☐ Latex _____ ☐ Other_____

Patient Printed Name _____

Consent to treat/Privacy Statement

The term "health care provider(s)" in this document means Wilde Foot & Ankle Clinic, its agent and employees.
I understand that as part of my health care, this organization originates and maintains health records describing my health history, symptoms, examinations and test results, diagnoses, treatment, and any plan for care including future treatment.
I understand that this information serves as:

1. Basis for planning my treatment and care
2. Information used to file my claim with the insurance company (procedure and diagnosis)
3. Means by which a third-party payer can verify that billed services were actually provided
4. A tool for routine health care operations including assessing quality and reviewing competency of your staff and/or other health care providers.

I understand that I have been provided with the Notice of Privacy Practices that provides more complete information of uses and disclosures. I understand that I have the right to review the notice before signing this consent. I understand any revised notice to the address I have provided. I understand that I have the right to restrict how my health information may be used or disclosed to carry out payment, treatment, or health care operations and that the organization is not required to agree to the restrictions requested. I understand that I have the right to revoke this consent in writing, except to the extent that the organization has already taken action on my behalf.

Permission is granted to all health care providers involved in my care to administer such examination, treatment, testing, and procedures as are deemed necessary in the course of my care.

- The following individual(s) is/are granted access to my health record. _____

_____

Financial Responsibility/ Assignment of Benefits

I the undersigned certify that I (or my dependent) have insurance coverage and hereby assign all insurance benefits, if any, otherwise payable to me, directly to Wilde Foot & Ankle Clinic, PA for services rendered. I agree to pay all charges that are not paid in full by assigned insurance. If such amounts due to the health care providers are not paid after reasonable notice, that account shall be deemed delinquent. In the event that I default on payment of my account, I agree to be responsible for collection fee and interest due on amounts in default. If the debt is assigned to a third party for collections, I agree to be responsible for collection fees and interest due on amounts in default.
I hereby authorize the doctor to release all information necessary to secure the payment of benefits from my insurance company(ies). I authorize the use of my signature below to reflect my agreement and authorization for the above named financial understanding and insurance submissions.

Please Note: If Medicaid is your Primary insurance, please call Community Health Center of Southeast Kansas at 620.231.9873 to receive treatment. If Medicaid is your Secondary Insurance you might be responsible for the amount that your primary insurance does not pay. *Unfortunately, the Medicaid program does not pay for podiatry services.*

Patient/Legal Representative Signature _____ Date _____

If Legal Representative, complete the following:

Print Name _____ Date of Birth _____

Address _____ City _____ State _____ Zip _____

Phone # _____

Witness _____ Title _____ Date _____