

**Patient Information**

Patient Last \_\_\_\_\_ MI \_\_\_\_\_ First \_\_\_\_\_  
Nickname \_\_\_\_\_ Social Security # \_\_\_\_\_ Date of birth \_\_\_\_\_  
Birth Sex: Male Female    Marital Status: Single Married Partnered Separated Widow Divorced  
Address \_\_\_\_\_ City \_\_\_\_\_ Phone # \_\_\_\_\_  
State \_\_\_\_\_ Zip code \_\_\_\_\_ email \_\_\_\_\_  
2nd Contact \_\_\_\_\_ Relationship \_\_\_\_\_ Phone # \_\_\_\_\_  
Primary Physician \_\_\_\_\_ Date Last Seen \_\_\_\_\_  
Pharmacy \_\_\_\_\_ City \_\_\_\_\_ Phone \_\_\_\_\_  
Employer \_\_\_\_\_ Work phone \_\_\_\_\_  
Who has access to my health information? Name \_\_\_\_\_ 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:** \_\_\_\_\_ ID# \_\_\_\_\_  
Name of Policy Holder \_\_\_\_\_ Group# \_\_\_\_\_  
Relationship \_\_\_ Self \_\_\_ Spouse \_\_\_ Dependent \_\_\_ Other    Date of birth \_\_\_\_\_  
Social Security # \_\_\_\_\_  
**Secondary Insurance:** \_\_\_\_\_ ID# \_\_\_\_\_  
Name of Policy Holder \_\_\_\_\_ Group# \_\_\_\_\_  
Relationship \_\_\_ Self \_\_\_ Spouse \_\_\_ Dependent \_\_\_ Other    Date of birth \_\_\_\_\_  
Social Security # \_\_\_\_\_

Receiving Automatic appointment reminders via email, text or phone: Opt out

**Medical History**

**Patient Name:** \_\_\_\_\_ **Date:** \_\_\_\_\_

- Personal Medical Hx:**
- |   |   |   |  |
|---|---|---|--|
| <input type="checkbox"/> Gout               | <input type="checkbox"/> Muscle Disorders | <input type="checkbox"/> Stomach Conditions     |  |
| <input type="checkbox"/> Arthritis          | <input type="checkbox"/> Heart Problems   | <input type="checkbox"/> Nerve Disorders        | <input type="checkbox"/> Thyroid Disorders |
| <input type="checkbox"/> Bleeding Disorders | <input type="checkbox"/> Hepatitis        | <input type="checkbox"/> Obesity                | <input type="checkbox"/> Vascular Disease  |
| <input type="checkbox"/> Cancer _____       | <input type="checkbox"/> Hyperlipidemia   | <input type="checkbox"/> Respiratory Conditions | <input type="checkbox"/> _____             |
| <input type="checkbox"/> Depression/Anxiety | <input type="checkbox"/> Hypertension     | <input type="checkbox"/> Skin Conditions        | <input type="checkbox"/> _____             |
| <input type="checkbox"/> Diabetes           | <input type="checkbox"/> Kidney Disease   | <input type="checkbox"/> Stroke                 | <input type="checkbox"/> _____             |

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

Surgery / Date: \_\_\_\_\_

\_\_\_\_\_

**Explain your foot/ankle problem**  Right  Left \_\_\_\_\_

Accident Date \_\_\_\_\_ Is the problem work related?  Yes  No

**List all medications/herbs/vitamins:**  NONE \_\_\_\_\_

\_\_\_\_\_

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

Penicillin \_\_\_\_\_  Sulfa Drugs \_\_\_\_\_  Betadine/Iodine \_\_\_\_\_

Contrast Dye \_\_\_\_\_  Latex \_\_\_\_\_  Other \_\_\_\_\_

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

Tobacco Use - How much? \_\_\_\_\_  Alcohol Use- How much? \_\_\_\_\_

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

Diabetes \_\_\_\_\_  Heart Disease \_\_\_\_\_  Rheumatology \_\_\_\_\_

Hypertension \_\_\_\_\_  Stroke \_\_\_\_\_  Cancer \_\_\_\_\_

Other Family History: \_\_\_\_\_

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. I consent to recording the patient visit to capture the necessary information for documentation and billing.

**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.*

**Appointment cancellation policy:**

- Rescheduling or cancelling appointments 3 times in 6 months are subject to dismissal.
- Notify the office at least 24 hours prior to the appointment if you are unable to make the appointment to avoid a \$25.00 charge.

Patient/Legal Representative Signature \_\_\_\_\_ Date \_\_\_\_\_

**If Legal Representative, complete the following:**

Print Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone # \_\_\_\_\_