JESSUP FOOT & ANKLE SPECIALISTS, PA
9601 HOLLY POINT DRIVE, SUITE 203
HUNTERSVILLE, NC 28078
PHONE: (704) 892-0949 FAX: (704) 987-6548

PATIENT INFORMATION FORM

DATE: ___/____/____

PATIENT NAME: ______________ ______________ ___ DATE OF BIRTH: ___/___/___ AGE: ___ SEX: M F
LAST FIRST MI

HOME ADDRESS: ________________________________ CITY/STATE: ____________________ ZIP: ___________

RACE:__________________ ETHNICITY:____________________ SOCIAL SECURITY #:__________________

MAY WE LEAVE A MESSAGE?

HOME PHONE #: (____) ____-______ YES NO

WORK PHONE #: (____) ____-______ YES NO

CELL PHONE #: (____) ____-______ YES NO

E-MAIL: _______________________________ YES NO

PRIMARY LANGUAGE: ______________________

DO YOU HAVE A LEGAL GUARDIAN OR HEALTHCARE POWER OF ATTORNEY? YES NO
IF YES, NAME: _______________________ RELATIONSHIP: ___________ PHONE #: (____) ____-______

EMERGENCY CONTACT: _______________________ RELATIONSHIP: ___________ PHONE #: (____) ____-______

PRIMARY CARE DOCTOR: ____________________________________ PHONE: ____________________________
PHARMACY: ________________________ LOCATION: ______________________ PHONE #: (____) ____-______

IS THERE A FAMILY MEMBER OR OTHER PERSON YOU WOULD LIKE FOR US TO SHARE YOUR MEDICAL INFORMATION?
_____ YES NAME(S) ____

_____ NO

WHO IS RESPONSIBLE FOR PAYMENT? _________________________ RELATIONSHIP TO PATIENT? _____________

ADDRESS: ____________________ CITY/STATE: ______________ ZIP: ________ PHONE #: (____) ____-_____

WHO REFERRED YOU TO US?____

YOUR MEDICAL HISTORY

HEIGHT:_________________ WEIGHT:___________________ SHOE SIZE:__________________
PLEASE LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING (INCLUDE PRESCRIPTIONS, OVER-THE-COUNTER MEDS AND HERBAL SUPPLEMENTS):

NAME	DOSE	HOW OFTEN DO YOU TAKE?

PATIENT NAME: ______________________________
DATE OF BIRTH: ____/____/_____

ALLERGIES: ☐ MEDICATIONS ____
☐ ANESTHESIA _________________________ ☐ FOODS ___________________________
☐ TAPE ☐ LATEX ☐ SHELLFISH ☐ IODINE ☐ OTHER ______________________________
☐ NONE KNOWN

HAVE YOU EVER HAD ANY OF THE FOLLOWING?

ACID REFLUX	Y	N	FIBROMYALGIA	Y	N	NEUROPATHY	Y	N
ANEMIA	Y	N	GOUT	Y	N	OPEN SORES	Y	N
ARTHRITIS	Y	N	HEART ATTACK	Y	N	PNEUMONIA	Y	N
ASTHMA	Y	N	HEART DISEASE/FAILURE	Y	N	POLIO	Y	N
BACK TROUBLE	Y	N	HEPATITIS	Y	N	RHEUMATIC FEVER	Y	N
BLADDER INFECTIONS	Y	N	HIV+/AIDS	Y	N	SICKLE CELL DISEASE	Y	N
ABNORMAL BLEEDING	Y	N	HIGH BLOOD PRESSURE	Y	N	SKIN DISORDER	Y	N
BLOOD CLOTS	Y	N	KIDNEY DISEASE	Y	N	SLEEP APNEA	Y	N
BLOOD TRANSFUSION	Y	N	LIVER DISEASE	Y	N	STOMACH ULCERS	Y	N
BRONCHITIS/EMPHYSEMA	Y	N	LOW BLOOD PRESSURE	Y	N	STROKE	Y	N
CANCER	Y	N	MIGRAINE HEADACHES	Y	N	THYROID DISEASE	Y	N
DIABETES	Y	N	MITRAL VALVE PROLAPSE	Y	N	TUBERCULOSIS	Y	N
OTHER CONDITIONS:								

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

_______________________________________ _______________________________________
_______________________________________ _______________________________________
_______________________________________ _______________________________________

SOCIAL HISTORY

MARITAL STATUS: ☐ SINGLE ☐ MARRIED ☐ PARTNERED ☐ SEPARATED ☐ DIVORCED ☐ WIDOWED

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

EMPLOYER: ________________________ OCCUPATION: ____________________________

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: ____

Patient Name: ________________________________
Date of Birth: ____/____/_____

Family History

Do you have a family history of: ☐ Diabetes ☐ Cancer ☐ Heart Disease ☐ High Blood Pressure
☐ Stroke ☐ Coronary Artery Disease ☐ Thyroid Disease ☐ Rheumatoid Arthritis
☐ Other ____

Review of Systems

*If you are experiencing any of the following please circle

Head: chronic headaches, concussions, dizziness, loss of consciousness. **Eyes:** glasses, contacts, double vision, blurred vision, blindness, cataracts. **Ears**: decreased or loss of hearing, ringing in the ears, chronic earaches. **Nose:** drainage or infection, blockage, bleeding, sinusitis. **Throat**: chronic tonsillitis, laryngitis, difficulty swallowing, loss of speech. **Cardiovascular:** chest pain, shortness of breath, palpitations, murmurs, heart valve disease, anemia, leg cramps. **Respiratory:** bronchitis, pneumonia, difficulty breathing, wheezing, chronic cough. **Gastrointestinal:** nausea, vomiting, diarrhea, constipation, weight gain or loss, blood in stool, black stool, excessive gas, loss of appetite. **Genitourinary:** chronic kidney or bladder infections, problems voiding, pain with urination, dark or bloody urine, discharge from penis or vagina. **Gynecologic:** Irregular or painful periods, absence of period if not in menopause, vaginal discharge.

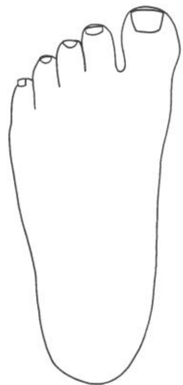
☐ **I am not experiencing any of the above symptoms.**

Current Problem

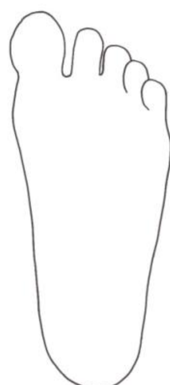
What specific problem brings you to our office today? ______________________________

Where is the pain/problem located? Please mark on the pictures below.

Left Foot



Top of Foot

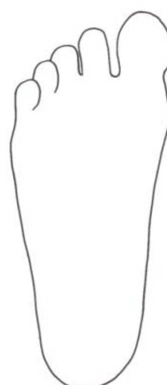


Bottom of Foot

Inside of foot

Outside of Foot

Right foot



Bottom of Foot

Top of Foot

Outside of Foot

Inside of foot

Revised April 2013

PATIENT NAME: ______________________________
DATE OF BIRTH: ____/____/_____

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

NOTICE OF PRIVACY PRACTICES (HIPPA REGULATIONS)

☐ YOU WERE PROVIDED WITH A DOCUMENT ENTITLED "NOTICE OF PRIVACY PRACTICES". IT IS REQUIRED BY GOVERNMENTAL REGULATIONS THAT ALL MEDICAL FACILITIES PROVIDE YOU WITH THIS NOTICE. PLEASE CHECK THE BOX TO ACKNOWLEDGE THAT YOU HAVE READ (OR HAD THE OPPORTUNITY TO READ IF YOU CHOSE) AND UNDERSTAND THE NOTICE. THIS IS A COPY OF THE NOTICE THAT IS YOURS TO KEEP. IF YOU DO NOT WANT THE COPY, SIMPLY RETURN IT TO THE RECEPTIONIST WITH YOUR OTHER MATERIALS.

TO THE BEST OF MY KNOWLEDGE, I HAVE ANSWERED THE QUESTIONS ON THIS FORM ACCURATELY. I UNDERSTAND THAT PROVIDING INCORRECT INFORMATION CAN BE DANGEROUS TO MY HEALTH. I UNDERSTAND THAT IT IS MY RESPONSIBILITY TO INFORM THE DOCTOR AND OFFICE STAFF OF ANY CHANGES IN MY MEDICAL STATUS.

________________________________ ________________________________
PRINT NAME OF PATIENT, PARENT OR GUARDIAN SIGNATURE OF DOCTOR

________________________________ ________________________________
IF OTHER THAN PATIENT, RELATIONSHIP TO PATIENT DATE

____
SIGNATURE

____
DATE

PATIENT NAME: ________________________________
DATE OF BIRTH: ____/____/_____

Patient Financial Policy

Your understanding of our financial policies is an essential element of your care and treatment. If you have any questions, please discuss them with our front office staff or supervisor.

- As our patient, you are responsible for all authorizations/referrals needed to seek treatment in this office.

- Unless other arrangements have been made in advance by you, or your health insurance carrier, payment for office services are due at the time of service. We will accept VISA, MasterCard, Discover, cash or check.

- Your insurance policy is a contract between you and your insurance company. As a courtesy, we will file your insurance claim for you if you assign the benefits to the doctor. In other words, you agree to have your insurance company pay the doctor directly. If your insurance company does not pay the practice within a reasonable period, we will have to look to you for payment.

- We have made prior arrangements with certain insurers and other health plans to accept an assignment of benefits. We will bill those plans with which we have an agreement and will only require you to pay the co-pay/co-insurance/deductible at the time of service.

- If you have insurance coverage with a plan with which we do not have a prior agreement, we will prepare and send the claim for you on an unassigned basis. This means your insurer will send the payment directly to you. Therefore, all charges for your care and treatment are due at the time of service.

- All health plans are not the same and do not cover the same services. In the event your health plan determines a service to be "not covered," or you do not have an authorization, you will be responsible for the complete charge. We will attempt to verify benefits for some specialized services or referrals; however, you remain responsible for charges to any service rendered. Patients are encouraged to contact their plans for clarification of benefits prior to services rendered.

- You must inform the office of all-insurance changes and authorization/referral requirements. In the event the office is not informed, you will be responsible for any charges denied.

- For most services provided in the hospital, we will bill your health plan. Any balance due is your responsibility.

- There are certain elective surgical procedures for which we require pre-payment. You will be informed in advance if your procedure is one of those. In that event, payment will be due one week prior to the surgery.

- Past due accounts are subject to collection proceedings. All costs incurred including, but not limited to, collection fees, attorney fees and court fees shall be your responsibility in addition to the balance due this office.

- There is a service fee of $25.00 for all returned checks. Your insurance company does not cover this fee.

Signature of Patient/Responsible Party: ____

Printed Name of Patient/Responsible Party ____ Date: _________________________

PATIENT NAME: ________________________________
DATE OF BIRTH: ____/____/_____

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CHARGES FOR MISSED APPOINTMENTS

Effective November 1, 2011, it is the policy of Jessup Foot & Ankle Specialists, PA, that patients missing scheduled appointments for office visits or procedures will be charged a **missed appointment fee**. This policy applies equally to all patients (Medicare, Medicaid, and Commercial). If the responsible party fails to pay the missed appointment fee prior to arrival for the next visit, the unpaid fee will be collected at the time of the visit, along with the required co-pays and other patient due balances.

MISSED OFFICE VISIT CHARGE=$25.00/OCCURRENCE

Definition of no-show missed appointment=failure to arrive for scheduled appointment without previous notification to Jessup Foot & Ankle Specialists, PA of cancellation.

______________________________________ ______________________________________
Patient Signature/Patient Representative Printed Name

________________________ ________________________
Relationship to Patient Date