



Covington Foot & Ankle Clinic

Welcome to the Covington Foot and Ankle Clinic. Our goal is to provide our patients with the best medical care possible.

PATIENT INFORMATION

Date of Appointment: _____

Name: _____ Male Female
First Last MI

Name you go by: _____ Date of Birth: _____ Age: _____ SS#: _____

Race: _____ Ethnicity: _____ Preferred Language: _____

Height: _____ Weight: _____ Shoe Size: _____ Type of shoes typically worn: _____

Marital Status: _____ Spouse/Partner Name: _____ # of Children: _____

Address: _____
Apt # City State Zip code

Home Phone: (____) _____ Cell Phone: (____) _____

Work Phone: (____) _____ E-Mail Address: _____

Preferred method of contact: Home Work Cell E-mail

Employer: _____ Occupation: _____

How did you hear about us? _____

Emergency Contact: _____ Phone: (____) _____
 Home Work Cell *Relationship to you*

PRIMARY INSURANCE

Insurance Company: _____ ID#: _____ Group #: _____

Subscriber: _____
First Last MI

Subscriber's Relationship to Patient: _____ Subscriber's Date of Birth: _____

Subscriber's SS#: _____ Subscriber's Employer: _____

Subscriber's address if different than above: _____

Does your insurance plan require a co-pay? Yes No Co-Pay Amount \$ _____

SECONDARY INSURANCE

Insurance Company: _____ ID#: _____ Group #: _____

Subscriber: _____
First Last MI

Subscriber's Relationship to Patient: _____ Subscriber's Date of Birth: _____

Subscriber's SS#: _____ Subscriber's Employer: _____

Name: _____ Age: _____ Date of Appointment: _____

PODIATRIC HISTORY

Reason for visit: _____

When did this problem start? _____

What caused the problem? _____

Was it a work-related injury/condition? Yes No

How would you describe the pain? Sharp Throbbing Dull and Achy Burning Other _____

Does the pain radiate? Yes No If yes, where? _____

How would you rate the pain on a scale of 0 (no pain) to 10 (severe pain)? _____

Time of the day the pain/condition is worse? _____

Has the pain/condition stayed the same, gotten worse, or improved over time? _____

What makes the pain/condition worse? _____

What makes the pain/condition better? _____

What previous treatment have you had and by whom? _____

What percentage of the day are you on your feet? _____

What type of exercise do you perform and how often? _____

Has the condition affected your ability to work, exercise, or perform other daily activities? Yes No

If yes, please explain: _____

SIGNATURE ON FILE & PERMISSION TO TREAT

I request that payments of authorized benefits be made on my behalf or for any services furnished me by **Covington Foot & Ankle Clinic**. I authorize any holder of information about me to release any information needed to determine these benefits or the benefits payable to related services to the insurance agent. I recognize my financial obligation of any co-insurance, co-pays or deductibles and non-covered services that may be required. I give permission to Dr. John Parmelee and his staff to evaluate and treat my foot/ankle condition.

Signature of Patient (or Guardian): _____ Date: _____

Name: _____ Age: _____ Date of Appointment: _____

MEDICAL HISTORY

Family Physician: _____ City: _____ Last Visit: _____

Current Health Problems: None

MEDICATIONS (include Dosage, Frequency and Route, i.e. by mouth, injection, etc.) You can give us a list to copy.

None

Name and location of pharmacy that you use: _____

Last tetanus shot: < 5 years < 10 years Unknown

ALLERGIES (include the reaction, i.e. rash, hives, itching, nausea/vomiting, swelling, difficulty breathing...)

<u>Reaction</u>	<u>Reaction</u>	<u>Reaction</u>
<input type="checkbox"/> None	<input type="checkbox"/> Tetracycline _____	<input type="checkbox"/> Iodine _____
<input type="checkbox"/> Penicillin _____	<input type="checkbox"/> Aspirin _____	<input type="checkbox"/> Latex _____
<input type="checkbox"/> Keflex _____	<input type="checkbox"/> Anti-inflammatories _____	<input type="checkbox"/> Adhesive tape _____
<input type="checkbox"/> Sulfa _____	<input type="checkbox"/> Codeine _____	<input type="checkbox"/> Metal/Jewelry _____
<input type="checkbox"/> Other: _____		

Smoke or did smoke? Yes No How long? _____ How many packs per day? _____

Still smoking? Yes No When did you quit? _____

Do you drink alcohol? Yes No How many drinks per week? _____

Is there a history of alcohol excess? Yes No Is there a history of recreational drug use? Yes No

Women: Are you pregnant? Yes No Could you be pregnant now? Yes No

PREVIOUS SURGERIES (include dates): None

MEDICAL PROBLEMS THAT RUN IN THE FAMILY: None

REVIEW OF SYSTEMS: Have **you** ever had a problem with any of the following:

<input type="checkbox"/> Recent fever	<input type="checkbox"/> Blood clots	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Anemia
<input type="checkbox"/> Weight change	<input type="checkbox"/> Raynaud's	<input type="checkbox"/> Skin ulcers	<input type="checkbox"/> Lungs
<input type="checkbox"/> Eyes	<input type="checkbox"/> Arthritis	<input type="checkbox"/> Numbness in feet	<input type="checkbox"/> Asthma
<input type="checkbox"/> Ears/Hearing loss	<input type="checkbox"/> Gout	<input type="checkbox"/> Depression	<input type="checkbox"/> Seizures
<input type="checkbox"/> Nose	<input type="checkbox"/> Cancer	<input type="checkbox"/> Anxiety	<input type="checkbox"/> Headaches
<input type="checkbox"/> Throat	<input type="checkbox"/> Skin disorders	<input type="checkbox"/> Fibromyalgia	<input type="checkbox"/> Kidneys
<input type="checkbox"/> Heart	<input type="checkbox"/> Psoriasis	<input type="checkbox"/> Fatigue/Weakness	<input type="checkbox"/> Bladder
<input type="checkbox"/> Blood pressure	<input type="checkbox"/> Back pain/Sciatica	<input type="checkbox"/> Chronic pain	<input type="checkbox"/> Stomach
<input type="checkbox"/> Circulation	<input type="checkbox"/> Hip pain	<input type="checkbox"/> Sleep apnea	<input type="checkbox"/> Liver/Hepatitis
<input type="checkbox"/> Leg cramps	<input type="checkbox"/> Knee pain	<input type="checkbox"/> Dementia/Alzheimer's	<input type="checkbox"/> Immune Disorder
<input type="checkbox"/> Muscle pain	<input type="checkbox"/> Other _____		

Name: _____ Age: _____ Date of Appointment: _____

FINANCIAL POLICY

We are committed to providing you with the highest quality medical and surgical care. In return, we ask you to be equally committed to being fully responsible for paying our fees. This will help in reducing our billing and administrative burdens, leaving more time for helping you. This dual commitment is the foundation of our relationship. Our goal is to maximize the quality of your care and minimize misunderstandings regarding fees and payments.

We accept many different insurance plans, however, all health plans are not the same and do not cover the same services.

- **MANAGED CARE PATIENTS/PRIVATE INSURANCE:**

If you are in a managed care plan (HMO, PPO, IPA) with whom we participate, we abide by our contract with them. In either managed care plans or private plans, we will bill your insurance company; however, you are responsible for paying any co-pays required by your plan at the time of treatment. In 30-45 days, your insurance company will send you an Explanation of Benefits (EOB) that tells you what your balance is, if any, to our office.

- **MEDICARE PATIENTS:**

We accept assignment for Medicare, however, that does not mean that all services are covered. Patients are responsible for paying their annual deductible if it has not yet been met. You are also responsible for any co-payments, which are usually 20% of the allowed amount for an item or service.

- **UNINSURED PATIENTS:**

Payment is due at the time of service.

- **ALL PATIENTS:**

~For your convenience, we will accept VISA, MasterCard, cash or check.

~There is a service fee of \$30.00 for all returned checks

I have read, understand and accept all responsibilities associated with this financial policy.

Signature of Patient (or Guardian): _____ Date: _____

DURABLE MEDICAL EQUIPMENT POLICY

In the event that the patient leaves the office with an item recommended in the care and treatment of their foot condition (inclusive of, but not limited to, custom made foot orthoses, ankle/foot orthoses, night splints, walking boots, pads, etc.), it is understood that such items are non-returnable and non-refundable.

It is the policy of this office to help obtain insurance benefits regarding a patient's individual coverage of these items by contacting the insurance company. This is a courtesy service which we are happy to provide; however, the Covington Foot & Ankle Clinic is **not** held responsible for the accuracy of the information received. Information received by phone is not a guarantee of payment and, if any doubt exists as to eligibility, it is highly recommended that you check your plan booklet for a detailed outline of your benefits or make a personal phone call to your insurance company. ***Please note, if these items are denied by insurance due to coverage limitations, the patient hereby accepts responsibility for the cost.***

Initials of Patient (or Guardian): _____ Date: _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Notice of Privacy Practices and have read (or had the opportunity to read if I so chose) and understood the Notice.

Signature of Patient (or Guardian): _____ Date: _____