



# INFORMATION SHEET

NAME \_\_\_\_\_

DATE OF BIRTH \_\_\_\_/\_\_\_\_/\_\_\_\_ AGE \_\_\_\_ WEIGHT: \_\_\_\_\_

ADDRESS \_\_\_\_\_

(CITY & STATE) (ZIP)

TELEPHONE # (\_\_\_\_) \_\_\_\_\_ SOC. SEC. # \_\_\_\_\_

CELL # (\_\_\_\_) \_\_\_\_\_ EMAIL \_\_\_\_\_

MALE  FEMALE MARITAL STATUS: (CIRCLE ONE) S M W D

OCCUPATION: \_\_\_\_\_ EMPLOYER: \_\_\_\_\_

WORK # (\_\_\_\_) \_\_\_\_\_

EMERGENCY CONTACT \_\_\_\_\_ TELEPHONE # (\_\_\_\_) \_\_\_\_\_

### MEDICAL INSURANCE:

MEDICARE # \_\_\_\_\_ MEDICAID # \_\_\_\_\_

### **OTHER INSURANCE INFORMATION:**

\_\_\_\_\_  
(INSURANCE COMPANY NAME) (NAME OF INSURED)

POLICY # \_\_\_\_\_ GROUP # \_\_\_\_\_

SOC. SEC. # OF INSURED \_\_\_\_\_ DATE OF BIRTH OF INSURED \_\_\_\_\_

### **WORKERS COMP INFORMATION ONLY**

**RESPONSIBLE PARTY/INSURANCE:** \_\_\_\_\_

ADDRESS \_\_\_\_\_

CONTACT NAME: \_\_\_\_\_ TELEPHONE #: \_\_\_\_\_

I HEREBY AUTHORIZE ANY PHYSICIAN, HOSPITAL OR MEDICAL CARE FACILITY TO PROVIDE ALL INFORMATION ON MY MEDICAL HISTORY AND TREATMENT TO FAANC. I HEREBY AUTHORIZE FAANC TO RELEASE ANY INFORMATION ACQUIRED IN THE COURSE OF MY EXAMINATION OR TREATMENT NEEDED TO FILE AN INSURANCE CLAIM WITH MY CARRIER. I HEREBY AUTHORIZE PAYMENT DIRECTLY TO FAANC FOR THE SURGICAL OR MEDICAL BENEFITS IF ANY, OTHERWISE PAYABLE TO ME UNDER THE TERMS OF MY INSURANCE. I UNDERSTAND AND AGREE THAT REGARDLESS OF MY INSURANCE STATUS, I AM ULTIMATELY RESPONSIBLE FOR THE BALANCE ON MY ACCOUNT FOR ANY PROFESSIONAL SERVICES RENDERED. **I AGREE TO PAY ANY AND ALL BALANCES FOR SERVICES NOT APPROVED OR DENIED BY MY INSURANCE ESPECIALLY IF THEY ARE NON-COVERED SERVICES.** I HAVE READ ALL INFORMATION ON THIS SHEET AND CERTIFY THIS INFORMATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE. I WILL NOTIFY YOU OF ANY CHANGES IN INFORMATION AND I UNDERSTAND THAT PAYMENT IS DUE AND PAYABLE AT THE TIME THAT SERVICES ARE RENDERED.

**ALL ACCOUNTS ARE PAST DUE AT NINETY (90) DAYS AND FINANCE CHARGES OF 10 % WILL BE ADDED PER MONTH. IN LIABILITY CASES, I AUTHORIZE THAT MY ATTORNEY PAY ALL CHARGES PLUS FINANCE CHARGES DIRECTLY TO THE FOOT AND ANKLE ASSOCIATES OF NC, PLLC.**

**IF YOUR ACCOUNT IS SENT TO A COLLECTION AGENCY, WHICH IS USUALLY AFTER 90 DAYS OF NON-PAYMENT, YOU WILL BE RESPONSIBLE FOR ALL COLLECTION AGENCY FEES, ALONG WITH YOUR ACCOUNT AND FINANCE CHARGES WHICH HAVE ACCRUED.**

\_\_\_\_\_  
PATIENT/PARENT SIGNATURE

\_\_\_\_\_  
DATE

# The Foot and Ankle Associates of NC

NAME: \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_

AGE: \_\_\_\_\_

HAVE YOU EVER HAD FLUROSCOPY (X-RAY) PERFORMED BEFORE?

YES \_\_\_\_\_ NO \_\_\_\_\_

IS THERE ANY POSSIBILITY OF PREGNANCY?

YES \_\_\_\_\_ NO \_\_\_\_\_

I HAVE READ AND FULLY UNDERSTAND THE QUESTIONNAIRE

SIGNED \_\_\_\_\_

DATE: \_\_\_\_\_



# The Foot and Ankle Associates of N.C.

**Please take the time to let us know how you were referred to us. This will let us keep track of where we are getting such wonderful patients!**

\_\_\_\_\_ By my family doctor \_\_\_\_\_

\_\_\_\_\_ By a friend / patient

\_\_\_\_\_ Radio (which one?) \_\_\_\_\_

\_\_\_\_\_ Newspaper (which one?) \_\_\_\_\_

\_\_\_\_\_ Flyer / Brochure

\_\_\_\_\_ Business Card

\_\_\_\_\_ Internet

\_\_\_\_\_ Health Fair (which one?) \_\_\_\_\_

\_\_\_\_\_ Other \_\_\_\_\_



## **CONSENT TO USE OR DISCLOSE INFORMATION FOR TREATMENT, PAYMENT OR HEALTH CARE OPERATIONS**

I hereby consent to the use or disclosure of my individually identifiable health information by FAANC in order to carry out treatment, payment or health care operation. I have received a copy of FAANC's NOTICE OF PRIVACY PRACTICES.

FAANC reserves for itself the right to change the terms of its Notice of Privacy Practices for Protected Health Information at any time. If FAANC does change the terms of its Notice of Privacy Practices, patients may obtain a copy of the revised Notice by mail.

I, the patient, retain the right to request that the Facility further restrict how my protected health information is used or disclosed to carry out treatment, payment or health care operations. The Facility is not required to agree to such requested restriction; however, if the Facility does agree to the requested restriction(s), such restrictions are then binding on the Facility.

At all times, I, the patient retain the right to revoke this Consent. Such revocation must be submitted to the Facility in writing. The revocation shall be effective except to the extent that the Facility has already taken action in reliance on the Consent.

The Facility may refuse to treat the Patient if he/she (or an authorized representative) does not sign the Consent form (except to the extent that the Facility is required by law to treat individuals). If the Patient (or authorized representative) signs this Consent form and then revokes the Consent, the Facility has the right to refuse to provide further treatment to the Patient as of the time of revocation (except to the extent that the Facility is required by law to treat individuals).

**I HAVE READ AND UNDERSTAND THIS INFORMATION. I HAVE RECEIVED A COPY OF THIS FORM AND I AM THE PATIENT OR I AM AUTHORIZED TO ACT ON BEHALF OF THE PATIENT TO SIGN THIS DOCUMENT VERIFYING CONSENT TO THE ABOVE STATED TERMS.**

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**Signature of Patient**

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**Date**

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**Signature of Person Signing on Behalf of Patient**

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**Signature of Witness**





**The Foot and Ankle Associates of N.C.**

*I, \_\_\_\_\_ hereby authorize  
the release of my medical records and/or labs to The  
Foot and Ankle Associates of North Carolina, PLLC.*

\_\_\_\_\_  
*Signature*

\_\_\_\_\_  
*Date*



# HISTORY AND PHYSICAL FORM



NAME \_\_\_\_\_ DATE \_\_\_\_\_

WHAT IS YOUR CHIEF COMPLAINT TODAY? \_\_\_\_\_

HOW LONG HAVE YOU HAD THIS COMPLAINT? \_\_\_\_\_

WHAT HAVE YOU DONE FOR THIS PROBLEM? \_\_\_\_\_

WHAT MAKES IT FEEL BETTER? \_\_\_\_\_

INTENSITY LEVEL OF PAIN? (PLEASE CIRCLE ONE) MILD 1 2 3 4 5 6 7 8 9 SEVERE

NAME AND NUMBER OF FAMILY MEDICAL PHYSICIAN \_\_\_\_\_

ADDRESS OF FAMILY PHYSICIAN \_\_\_\_\_

TELEPHONE # / FAX # \_\_\_\_\_ / \_\_\_\_\_

## YOUR PAST MEDICAL HISTORY

- |   |   |
|---|---|
| <input type="checkbox"/> DIABETES             | <input type="checkbox"/> RHEUMATIC FEVER    |
| <input type="checkbox"/> HIGH BLOOD PRESSURE  | <input type="checkbox"/> SKIN PROBLEMS      |
| <input type="checkbox"/> HIGH CHOLESTEROL     | <input type="checkbox"/> NERVOUS CONDITION  |
| <input type="checkbox"/> SEIZURE DISORDERS    | <input type="checkbox"/> STROKE             |
| <input type="checkbox"/> BLEEDING DISORDERS   | <input type="checkbox"/> SICKLE CELL ANEMIA |
| <input type="checkbox"/> HEART DISEASE        | <input type="checkbox"/> HEPATITIS          |
| <input type="checkbox"/> OTHER, EXPLAIN _____ |   |

## PAST SURGICAL HISTORY

DATE \_\_\_\_\_ TYPE OF SURGERY \_\_\_\_\_  
DATE \_\_\_\_\_ TYPE OF SURGERY \_\_\_\_\_

## ALLERGIES

- |   |  |
|---|--|
| <input type="checkbox"/> PENICILLIN           | <input type="checkbox"/> LOCAL ANESTHETICS |
| <input type="checkbox"/> ASPIRIN              | <input type="checkbox"/> FOOD              |
| <input type="checkbox"/> CLOTHING             | <input type="checkbox"/> TAPE              |
| <input type="checkbox"/> CODEINE              | <input type="checkbox"/> SULPHUR           |
| <input type="checkbox"/> OTHER, EXPLAIN _____ |  |

## FAMILY HISTORY

- |   |   |
|---|---|
| <input type="checkbox"/> DIABETES                 | <input type="checkbox"/> CIRCULATORY PROBLEMS |
| <input type="checkbox"/> PROBLEMS WITH ANESTHESIA | <input type="checkbox"/> BLEEDING DISORDERS   |
| <input type="checkbox"/> HYPERTENSION             |   |

## DOCTOR'S COMMENTS

- SMOKE (HOW MANY PACKS A DAY) \_\_\_\_\_  ALCOHOL  COFFEE (CUPS / DAY) \_\_\_\_\_  
 HOW MANY YEARS (SMOKING) \_\_\_\_\_  
 SUBSTANCE ABUSE (DESCRIBE) \_\_\_\_\_

## REVIEW OF SYSTEMS

HEAD, EARS, EYES, NOSE, THROAT \_\_\_\_\_ GENITOURINARY \_\_\_\_\_  
RESPIRATORY \_\_\_\_\_ NEUROPSYCHIATRIC \_\_\_\_\_  
GASTROINTESTINAL \_\_\_\_\_ LOCOMOTOR \_\_\_\_\_  
CARDIOVASCULAR \_\_\_\_\_ OTHER / EXPLAIN \_\_\_\_\_