ARCH FOOT & ANKLE

DR. JENNY FUEHRER
1327 SUNSET DR.
SUITE 300
NORWALK, IA 50211

NAME: _____
LAST **FIRST** **MIDDLE**

ADDRESS: _____
STREET **APT#** **CITY** **STATE** **ZIP**

HOME # (_____) _____ **CELL# (_____)** _____

E-MAIL:_____ **PREFERENCE: HOME** ☐ **CELL** ☐ **E-MAIL** ☐

AGE: _____ **DATE OF BIRTH:** _____ **MALE** ☐ **FEMALE** ☐

YOUR OCCUPATION: _____**EMPLOYER:** _____

EMERGENCY CONTACT:_____ **PHONE (_____)** _____

MARITAL STATUS: **S:**☐ **M:**☐ **W:**☐ **D:**☐

PRIMARY CARE PHYSICIAN:_____ **DATE OF LAST VISIT:** _____

HOW DID YOU HEAR ABOUT OUR OFFICE?

□ Online search □ Social Media □ Newspaper Ad □ Word of mouth □ Driving by/signage
□ Primary care physician

WHO REFERRED YOU TO OUR OFFICE? _____

MEDICAL INFORMATION

ALLERGIES

Do you have a history of skin reaction or other adverse reaction to any medication, please list below:

_____

MEDICATIONS (Dose & Frequency): If you have a list, please provide to front desk staff.

_____

_____

_____

FAMILY HISTORY

Has anyone in your family ever been diagnosed with the following? Name the relationship next to the condition in the space provided.

☐ **Heart Disease** _____ □ **Cancer** _____ □ **Diabetes** _____
☐ **Circulatory Disease** _____ □ **Hypertension** _____ □ **Arthritis** _____
☐ **Neurological Problems** _____ □ **Skin Disease** _____ □ **Foot Problems** _____

Additional notes:

_____

SOCIAL HISTORY

Are you on a special diet?	**□ Yes**	**□ No**	**If yes, what kind? _____**
Do you smoke?	**□ Yes**	**□ No**	**If yes, how many packs per day? # _____ for # _____ years.**
Do you drink alcohol?	**□ Yes**	**□ No**	**If yes, how often? _____**
History of substance abuse?	**□ Yes**	**□ No**	**If yes, what substance(s)? _____**
Do you live alone?	**□ Yes**	**□ No**	**Do you have children? □ Yes □ No**
Are you pregnant?	**□ Yes**	**□ No**	**Are you taking Birth Control Pills? □ Yes □ No**

SURGICAL HISTORY

_____

_____

PAST MEDICAL HISTORY

Have you ever had any of the following?

☐ **Acid reflux**	□ **Blood Transfusion**	□ **HIV+/AIDS**	□ **Osteoporosis**
☐ **Anemia**	□ **Cancer**	□ **High Blood Pressure**	□ **Osteopenia**
☐ **Arthritis**	□ **Diabetes**	□ **Kidney Disease**	□ **Pneumonia**
☐ **Asthma**	□ **Fibromyalgia**	□ **Liver Disease**	□ **Sickle Cell Disease**
☐ **Back problems**	□ **Gout**	□ **Low Blood Pressure**	□ **Sleep Apnea**
☐ **Bladder Infections**	□ **Heart Attack**	□ **Lung Disease**	□ **Stroke**
☐ **Abnormal Bleeding**	□ **Heart Disease**	□ **Neuropathy**	□ **Thyroid Disease**
☐ **Blood Clots**	□ **Hepatitis**	□ **Open wounds**	□ **Varicose Veins**

☐ **Other _____**

CURRENT PROBLEM

HEIGHT: _____ **WEIGHT: _____**

SHOE SIZE: _____

What specific problem brings you to our office today?

_____

_____

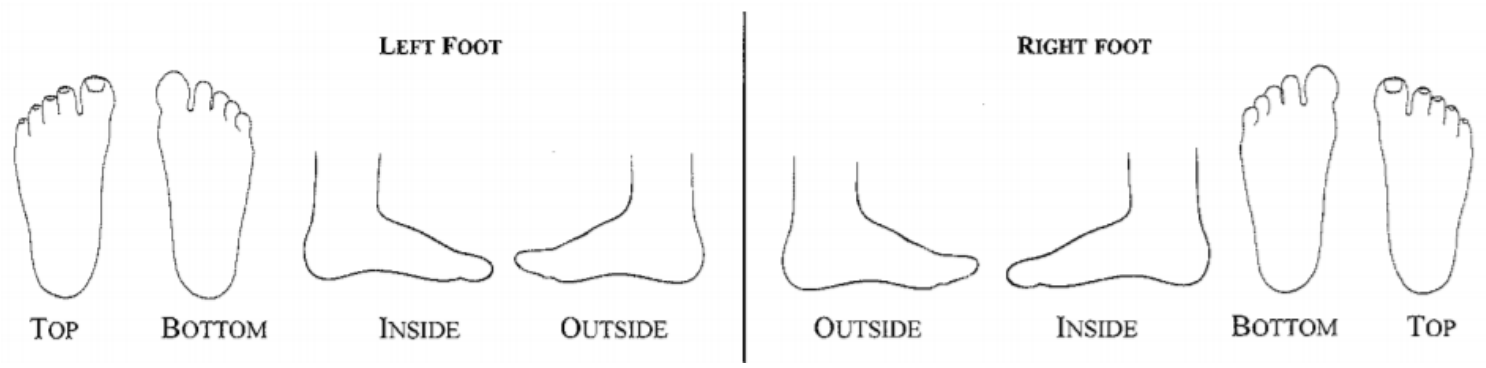
How long have you had this problem? _____

Have you been treated for this problem? By whom?_____

Did your pain or problem:

☐ Begin suddenly ☐ Gradually developed over time

Where is the pain or problem located? Please mark on the diagram below:



Describe your pain:

☐No pain	☐Dull	☐Burning	☐Throbbing	☐Other:
☐Sharp	☐Aching	☐Radiating	☐Stabbing	_____

How would you rate your pain on a scale of 0 – 10? (Please circle)

(*No pain*) **0 1 2 3 4 5 6 7 8 9 10** (*worst pain possible*)

NOTES: _____

_____

_____

_____

_____

To the best of my knowledge, the above information submitted is correct. I understand that giving incorrect information can be dangerous to my health. It is my responsibility to inform this office of any changes in my medical status. I, hereby, give my permission to Dr. Fuehrer to diagnose and administer treatment of my foot condition.

_____ _____

SIGNATURE OF PATIENT OR LEGAL GUARDIAN **DATE**

PATIENT AGREEMENTS AND AUTHORIZATIONS

CONSENT FOR TREATMENT:
I hereby consent to the treatment provided by Arch Foot and Ankle, and its employees or designees. I authorize the physical health care services deemed necessary or advisable by my caregivers to address my needs.

PRIVACY POLICY:
I acknowledge having received Arch Foot and Ankle's, "Notice of Privacy Policies". My rights, including the right to see and copy my record, to limit disclosure of my health information, and to request an amendment to my record, are explained in the Policy. I understand that I may revoke in writing my consent for release of my health care information, except to the extent that Arch Foot and Ankle has already made disclosures with my prior consent.

HMO POLICIES:
I understand that it is my responsibility to obtain referrals from my primary care physician. If I do not supply Arch Foot and Ankle with a referral for any appointment where one is required, I understand that I will be responsible for payment in full at the time of service.

AUTHORIZATION FOR RELEASE OF PERSONAL HEALTH INFORMATION:
I authorize use and disclosure of my personal health information for the purposes of diagnosing or providing treatment to me, obtaining payment for my care, or for the purposes of conducting the healthcare operations of Arch Foot and Ankle. I authorize Arch Foot and Ankle to release any information required in the process of applications for financial coverage for the services rendered. This authorization provides that Arch Foot and Ankle may release objective clinical information related to my diagnoses and treatment, which may be requested by my insurance company or its designated agent.

PRIOR AUTHORIZATIONS AND BENEFIT INFORMATION:
As a courtesy to our patients, Arch Foot and Ankle will check benefits prior to procedures and office visits. The information obtained from the insurance company is not guaranteed and may not be accurate. It is my responsibility as the patient to contact my insurance company prior to any treatment to confirm prior authorization is required.

PAYMENT TERMS:
I agree to pay any copayments, as required, on the day services are rendered. Payment for charges is due on the date of service with the exception of insurance carriers for which Arch Foot and Ankle is under contract to file directly. If I receive a bill for those services not covered by my insurance company, I will pay for these charges within 30 days of the statement date. Accounts not paid in full within 90 days will be sent to collections. If I do not have insurance, I agree to pay for all charges resulting from services on the same day of service.

_____ _____

PRINTED NAME OF PATIENT **PRINTED NAME OF LEGAL GUARDIAN**

_____ _____

SIGNAURE OF PATIENT OR LEGAL GUARDIAN IF PATIENT IS UNDER 18 **DATE**