Associated Foot & Ankle Specialists, LLC

2097 Henry Tecklenburg Dr.
Unit #210, Charleston SC, 29414
(843) 852 - 9444

Patient Information

Referred by: _____

Last Name: _____ Sex: ☐Male ☐Female

First Name: _____ Date of Birth: ___/___/____ Age ____ SSN: _____-____-_____

Marital Status: ☐Married ☐Single ☐Separated ☐Divorced ☐Widowed Ethnicity: ☐Hispanic or Latino ☐Not Hispanic or Latino

Race: ☐American Indian or Alaska Native ☐Asian ☐Black or African American ☐Native Hawaiian or OPI ☐White or Caucasian

Student Status: ☐Full ☐Part ☐N/A Employment: ☐Full ☐Part ☐N/A Employer: _____

Home Address: _____ City: _____ State: _____ Zip: _____

Email Address: _____

Phone: Primary: ( ) _____ Secondary: ( ) _____

May we leave a voice message to remind you about appointments on the phone numbers above? Yes _____ No _____

Pharmacy Name/ Address/ Phone number: _____

Emergency Contact Name: _____

Relationship: _____ Phone Number: ( ) _____

Guarantor/ Responsible Person (if different from patient) MUST BE COMPLETED IF PATIENT UNDER 18

Last Name: _____ Sex: ☐Male ☐Female

First Name _____ Date of Birth: ___/___/____ Age ____ SSN:_____-____-_____

Relationship to patient: _____

Mailing Address (if different from patient): _____ City: _____

State: _____ Zip: _____

Phone (if different from patient): Primary: ( ) _____ Secondary: ( ) _____

Insurance Information

Primary Insurance

Insurance Company: _____

Policyholder Name: _____

Policy Holder Date of Birth: _____

Member or Policyholder ID#: _____

Secondary Insurance

Insurance Company: _____

Policyholder Name: _____

Policy Holder Date of Birth: _____

Member or Policyholder ID#: _____

Ongoing Communication Regarding Your Health Care

We may release/ disclose your health information with the following people or organizations:

Name (Physician, family, etc.)	Phone/ Fax	Relationship

A separate **Authorization to Release Information Form** must be completed if the information is being released to anyone other than the people or organizations listed above.

Authorization, Assignment of Benefits, Consent for Treatment and Referral Medical Release

I hearby authorize Associated Foot & Ankle Specialists, LLC physicians and staff to use and release my protected health information for treatment payment and healthcare operations as allowed by HIPPA and as described in the Associated Foot & Ankle Specialists, LLC Privacy Policy. I have been provided a copy of the Associated Foot & Ankle Specialists, LLC Privacy Policy and/or Notice of Information Practices.

I allow the release of medical information including complete medical records, test results, and billing information to my insurance company and to other medical professionals and medical care institutions that I may be referred to for treatment.

I allow payment made directly to Associated Foot & Ankle Specialists, LLC for all medical or surgical benefits otherwise payable to me under terms of my insurance. I understand that I am financially responsible for paying all co-payments, deductibles and non-overed services. A photocopy of this form shall be considered as effective and as valid as the original.

I hereby authorize Associated Foot & Ankle Specialists, LLC to give me medical treatment. I understand that I have the right to refuse any procedure/treatment at any time. I understand that I have the right to discuss all medical treatments with my provider.

To the best of my knowledge the information I have given on this form is accurate and true. I know it is my or my legal guardian's responsibility to keep this practice and physician informed of changes to any of my contact information; failure to do so may interfere with the ability to contact me concerning my healthcare.

Signature of patient, parent or guardian	Print Name	Date

E-Prescribing Consent

E-Prescribing is defined as a physician's ability to electronically send an accurate, error free and understandable prescription directly to a pharmacy from the point of care. E-Prescribing greatly reduces medication errors and enhances patient safety. The Medicare Modernization Act (MMA) of 2003 listed standards that have to be included in an E-Prescribing Program. These include:

- Formulary and Benefit Transactions – Gives the prescriber information about which drugs are covered by the drug benefit plan.
- Medication History Transactions – Provides the physician with information about medications the patient is already taking to minimize the number of adverse drug events.

By signing this consent form you are agreeing that Associated Foot & Ankle Specialists, LLC can request and use your prescription medication history from your pharmacy and E-Prescribe your prescriptions to the pharmacy of your choice.

Signature of patient, parent or guardian	Print Name	Date

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Today's date: _____

Patient Name: _____ DOB: _____

Did a physician refer you to this office? ☐ No ☐ Yes If yes, please name: _____

Reason for today's visit: _____ Primary Physician _____
(Include symptoms and length of problem)

Is this related to an injury? ☐ No ☐ Yes If yes, when and where: _____

Social History

Tobacco History

☐Never Smoker
☐Quit Smoking – How long ago? _____
☐Current every day smoker ___ packs/day/____years

Alcoholic Beverage Consumption

☐Never ☐ Occasionally
☐Currently
☐History of abuse

Allergies: ☐ None

☐Penicillin
☐Sulfa
☐Other: _____

Personal Medical History

Have you ever been diagnosed or treated for any of the following conditions? ☐ No Known medical diagnoses

☐Diabetes	☐Stroke	☐Arthritis	☐Kidney Disease	☐Poor Circulation	☐Cancer
☐Hepatitis	☐Back problems	☐Tuberculosis	☐HIV/AIDS	☐Stomach/bowel issues	☐Anxiety
☐Depression	☐Heart disease	☐COPD	☐Asthma	☐Varicose Veins	☐Neuropathy
☐Ulcers of foot	☐Thyroid disease	☐High/low Blood Pressure		☐High/low cholesterol	☐Migraines
☐ Alzheimer's/dementia		☐Fibromyalgia	☐Other: _____		

Medications

Please list all medications (including vitamins and over the counter medications):

_____ _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ ☐ No Medications

Surgical History

Please list **ALL** surgeries:

_____ _____ _____
_____ _____ ☐ No surgeries

Family History

Is there any family history of (please circle): ☐ No known family history of any of the following

DIABETES: Mother / Father / Brother / Sister
CANCER: Mother / Father / Brother / Sister
HIGH BLOOD PRES: Mother / Father / Brother / Sister
STROKE: Mother / Father / Brother / Sister
HEART PROBLEMS: Mother / Father / Brother / Sister
POOR CIRCULATION: Mother / Father / Brother / Sister