PATIENT INFORMATION

LORDS FOOT & ANKLE CENTER

Name: _____Gender: M/F SS#_____
Birthday: ___/____/_____ E-Mail: _____
Address: _____
City: _____ State: ___ Zip: _____
Home : (_____)_____Cell: (_____)_____
Work: (_____) _____ Employer: _____

Marital Status: (Circle One) Single, Married, Widowed, Divorced
Student Status: (Circle One) Full-time, part-time,
Employment Status: Full-time, part-time, unemployed, retired
Spouse / Partner Name: _____
My primary language is _____
Do we have your permission to contact you at work?: Yes / No
Ethnicity: (Circle One) Declined, American Indian or Alaskan Native, Asian, Black or Afro-American, Native or Hawaiian Specific Islander or White.
Who is your **PRIMARY CARE** physician? _____
Who **REFERRED** you to our clinic? _____

ALLERGIES: (Circle One) YES/ NO (IF YOU ANSWERED YES, PLEASE CHECK THE BOXES THAT PERTAIN TO YOU.)

LOCAL ANETHESIA		PENICILLIN		SULFA		OTHER *(PLEASE EXPLAIN BELOW)*
ANTIBIOTICS		ASPIRIN		CODEINE		

OTHER:_____
_____

CURRENT MEDICATIONS: _____

PAST / PRESENT / MEDICAL HISTORY (PLEASE CHECK THE BOXES THAT PERTAIN TO YOU)

ANEMIA		BREATHING ISSUES		HEART DISEASE		LIVER DISEASE		SLEEP APNEA	
ANXIETY		CANCER		HEPATITIS		MENTAL ILLNESS		STROKE	
ASTHMA		DEPRESSION		HIGH BLOOD PRESSURE		NEUROPATHY		SYPHILLIS	
BLOOD CLOTS		DIABETES		HIV		PROLAPSE MITRAL VALVE		THYROID DISEASE	
BLOOD DISORDER		GOUT		KIDNEY DISEASE		SKIN DISORDER		TUBERCULOSIS	

OTHER DISEASES: _____

PAST SURGICAL HISTORY: (DETAILS): _____

_____

FAMILY HISTORY (PLEASE CHECK THE BOX IF ANY OF THE FOLLOWING RUN IN YOUR FAMILY)

ALZHEIMER'S		BLEEDING DISORDER		CANCER		CIRCULATION PROBLEMS		DIABETES	
HEART DISEASE		NEUROLOGICAL		ARTHRITIS		BLOOD CLOTS		CATARACTS	
DEPRESSION		EMPHYSEMA		HIGH BLOOD PRESSURE		STROKE			

SOCIAL HISTORY

TOBACCO: (CIRCLE ONE) NEVER NO LONGER CURRENT USER
ALCOHOL: (CIRCLE ONE) NEVER NO LONGER SOCIAL MODERATE HEAVY
RECREATIONAL DRUGS: (CIRCLE ONE) NEVER NO LONGER CURRENT USER

IMMUNIZATIONS

ARE YOUR IMMUNIZATIONS CURRENT? (*CIRCLE ONE*) NO / YES

WHAT BRINGS YOU IN TODAY? _____

_____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES:

☐ I ACKNOWLEDGE THAT I WAS PROVIDED A COPY OF THE NOTICE OF PRIVACY PRACTICES AND THAT I HAVE READ (OR HAD THE OPPORTUNITY TO READ IF I SO CHOSE) AND UNDERSTAND THE NOTICE.

REFERRAL POLICY

IF YOUR INSURANCE IS PART OF A MANAGEMENT CAR PLAN (HMO, POS, EPO, ETC.) FAILURE TO OBTAIN A VALID REFERRAL FROM YOUR PRIMARY CARE PHYSICIAN (PCP) MAY RESULT IN REDUCED OR NO BENEFITS BEING PAID.

NON-COVERED FOOT CARE

YOUR INSURANCE CARRIER MAY DETERMINE THAT YOUR FOOT CARE IS EXCLUDED SERVICE, IN WHICH CASE NO REIMBURSEMENT WILL BE MADE. SHOULD THIS OCCUR, THE RESPONSIBILITY OF PAYMENT WILL REMAIN YOURS AS THE RECIPIENT OF THESE SERVICES. (THIS INCLUDES ORTHOTICS, SPLINTS, OVER THE COUNTER MEDICATIONS, HEEL CUPS, PADS AND TOE SEPARATORS, I.E. ANYTHING THAT IS GIVEN TO YOU IN THIS OFFICE THAT YOUR CARRIER MAY NOT PAY).

FINANCIAL RESPONSIBILITY

PAYMENT IS EXPECTED AT THE TIME OF YOUR VISIT. WE ACCEPT CASH, CHECK OR MOST CREDIT CARDS. AS OUR PATIENT YOU ARE RESPONSIBLE FOR ALL PAYMENTS OF ANY DEDUCTIBLE, CO-INSURANCE, CO-PAY OR NON-COVERED SERVICES. YOUR INSURANCE POLICY IS A CONTRACT BETWEEN YOU AND YOUR INSURANCE COMPANY. AS A COURTESY, WE WILL FILE YOUR INSURANCE CLAIM FOR YOU. AS OUR PATIENT YOU ARE RESPONSIBLE FOR ANY UNPAID BILL 60 DAYS AFTER INSURANCE IS FILED. IF FOR ANY REASON THE ACCOUNT BECOMES DELINQUENT, I AGREE TO PAY FOR ALL COLLECTION AND LEGAL FEES. I AUTHORIZE DR. DERIC LORDS, AND /OR DR. ROBERT LORDS TO RELEASE MEDICAL INFORMATION PERTINENT TO FILING OF AN INSURANCE CLAIM FOR ME. THERE IS A SERVICE FEE OF $25.00 FOR ALL RETURNED CHECKS. I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO THE UNDERSIGNED PHYSICIAN FOR SERVICES RENDERED.

* TO THE BEST OF MY KNOWLEDGE, I HAVE ANSWERED THE QUESTIONS ON THESE FORMS 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.

*** PATIENT NAME:** (PLEASE PRINT) _____
*** SIGNATURE:** _____ DATE: _____
(PATIENT, PARENT, OR LEGAL GUARDIAN)