Welcome to Our Practice!

We're so glad that you chose us and we will do our very best to make your visit both pleasant and enjoyable.

Name _____ DOB _____

Address _____ Gender _____

City _____ State _____ Zip _____

Mobile _____

Email _____

Preferred Pharmacy _____ Phone _____

Primary Care Doctor _____

Patient Height _____ Patient Weight _____ Shoe size _____

How did you hear about us? _____

Women: Currently Nursing? Yes No Currently Pregnant? Yes No

If the patient is a Minor, what is the Relationship of person Accompanying to the patient?

Father Mother Sibling Grandparent Legal Guardian Other _____

Party responsible for payment _____ Phone _____

Address _____ City _____ State _____

By signing below,

1. I am acknowledging that I have read or had the opportunity to read, the Notice of Privacy Practices. (Copy available at the desk)

2. I authorize Infinity Foot and Ankle or its staff to disclose my individually identifiable health information to insurance carrier(s) for the purpose of obtaining payment to the doctor for services rendered and allow insurance companies to process the claim. I understand that this authorization is voluntary.

_____ _____

Signature Date

Name _____ DOB:_____

Allergies: None Penicillin Sulfa Iodine Latex

Other _____

Type of Allergic Reaction: Rash Itching Blisters Swelling

Other _____

Surgeries you've had: None Tonsillectomy Hysterectomy Appendectomy Bypass Angioplasty

Other surgeries _____

_____

Complications from surgery: None _____

Tobacco Use: Never Past Use Current Use Type _____

Amount per day _____ Number of Years of Use _____

Alcohol Use: Never Past Use Current Use Type _____

Recreational Drug Use: Never Past Use Current Use Type _____

Circle any symptoms you are having

General:	Fever	Chills			
Eyes:	Change in Vision	Blurred Vision	Double Vision		
Cardiovascular:	Leg Pain While Sleeping	Leg Swelling	Leg Pain While Walking		
Respiratory:	Cough	SOB			
Musculoskeletal:	Bone/Joint Pain	Sore Muscles	Weakness		
Neurologic:	Numbness	Tingling	Burning Sensation	Dizziness	Poor Balance
Endocrine:	Thirsty	Urinating Frequently			
Integument:	Rash	Itching	Wounds		

_____

_____

Name _____ DOB: _____

Personal Medical History

☐ ADHD
☐ Alcoholism
☐ Anemia
☐ Anxiety
☐ Arthritis
☐ Asthma
☐ Arrhythmia
☐ Bipolar
☐ Bladder Problems
☐ Bleeding Problems
☐ Cancer _____
☐ Congestive Heart Failure
☐ Crohn's Disease
☐ COPD/Emphysema
Other _____
_____

☐ Dementia
☐ Depression
☐ Diabetes
☐ Diverticulitis
☐ DVT
☐ GERD(Reflux)
☐ Glaucoma
☐ Gout
☐ Headache
☐ Heart Attack
☐ Hiatal Hernia
☐ High Blood Pressure
☐ Kidney Stones
☐ Kidney Disease
☐ High Cholesterol
☐ HIV
_____

☐ Hepatitis
☐ Irritable Bowel Syndrome
☐ Lupus
☐ Liver Disease
☐ Macular Degeneration
☐ Neuropathy
☐ Osteopenia/Osteoporosis
☐ Parkinson's Disease
☐ Peripheral Vascular Disease
☐ Pulmonary Embolism
☐Rheumatoid Arthritis
☐ Seizure Disorder
☐ Sleep Apnea
☐ Stroke
☐ Thyroid Disorder
☐ Ulcerative Colitis
_____

What brings you into our office today? _____

Is the problem from an injury? No Yes _____

Rate your pain: 0 1 2 3 4 5 6 7 8 9 10

Location (Right/Left)(Foot/Toe/leg) of problem/pain?_____

Describe type of pain: Burning Throbbing Aching Stabbing Tingling

How long have you had this problem? _____

How did the problem start? Slowly over time Rapidly _____

How has the problem been over time? Worsened Stayed the same Improved

Have you seen anyone else with this problem? No Yes _____

Have you had any treatment for the problem? No Yes _____

Have you had this problem before? No Yes _____

What seems to make the problem worse? Nothing _____

What seems to make the problem better? Nothing _____

Name _____ DOB: _____

Medication List

Medication Name	Medication Name

If you are currently **NOT** taking any medication, please **initial** _____.

Office use Only

_____
_____
_____
_____
_____
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_____
_____

Financial Policy

We will collect your deductible, copay, coinsurance and any uncovered services or the percent you are responsible for at the time of visit. **Please be prepared to pay at the time of check in before you are seen by the doctor. We do not bill for deductibles.** It is the patient's responsibility to know the terms of their insurance plans. We obtain our information from your insurance company's provider portal.

We will file your claim with your insurance company as a provider for your plan. If your insurance denies payment for services rendered it becomes patient responsibility. Should your account become delinquent over 90 days it is transferred to a collection agency. Fees may apply.

Self Pay Patients : This category includes patients with no insurance and the patients who have an insurance plan with which we do not participate.

Payment for medical services is required at time of visit. We accept cash, check and all credit cards, debit cards with a service fee of $2.00.

If you have any questions regarding this financial policy, please ask or call before you are seen by the doctor.

_____ _____

Patient or Guardian Signature Date

_____

Print Name

Communication Consent

Name _____

Date of birth _____

I consent to receive communications from Infinity Foot and Ankle by:

☐ Automated reminder Voice messages

Home Phone Number _____

☐ Automated reminder Text messages

Cell Phone Number _____

☐ Automated reminder Email messages

Email Address _____

_____ _____

Signature Date

Cancellation Policy

Infinity Foot and Ankle is committed to providing all of our patients with the very best care. In order to do that we must manage our schedule to both maximize flow and maintain adequate patient volume. Late cancellations (less than 48 hours in advance of appointment) and no-shows hamper our ability to do that.

Please, if you are unable to make your appointment, call us at 678-639-4209
48 hours prior to your scheduled appointment to notify us of any changes or cancellations. To cancel a Monday appointment, please call our office by Friday before 10am.

If appointments are not canceled by at least **48** hours prior to your scheduled appointment, a late cancellation fee will be charged in the amount of $75.

Thank you in advance for your understanding.

_____ _____

Printed Name Date

_____

Signature