

# WELCOME TO HUNTINGTON FOOT & ANKLE CLINIC, INC!

Please take a few moments to **COMPLETELY** fill out the following questionnaire.

## Patient Information

Name: First \_\_\_\_\_ Middle \_\_\_\_\_ Last \_\_\_\_\_

Date of Birth \_\_\_\_\_ Phone # (\_\_\_\_) \_\_\_\_\_

Address: Street or Box# \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Social Security # \_\_\_\_\_

Marital Status: Single \_\_\_\_\_ Married \_\_\_\_\_ Divorced \_\_\_\_\_ Widowed \_\_\_\_\_

How did you hear about us? Newspaper \_\_\_; Sign \_\_\_; Friend or Family \_\_\_; Referral from Dr. \_\_\_\_\_

Yellow Pages, Which one? Charleston, Chesapeake, Huntington, Ironton, Wayne

Name of a person who does not live with you whom we can contact in case of an emergency:

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Phone # \_\_\_\_\_

Is this visit the result of an accident? \_\_\_\_\_ If yes, date it happened. \_\_\_\_\_

Did it happen at home \_\_\_; work \_\_\_; school \_\_\_; recreation \_\_\_; auto \_\_\_; motorcycle \_\_\_; other \_\_\_ State \_\_\_\_\_

Please fill out the following information for the person whose name the insurance is under.

Name of PRIMARY insurance Co. \_\_\_\_\_

Name Person insured \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

**Date of Birth of insured** \_\_\_\_\_ **SS# of insured** \_\_\_\_\_

Policy# \_\_\_\_\_ Group# \_\_\_\_\_

Name of 2<sup>nd</sup> insurance Co. \_\_\_\_\_

Name of person insured \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

**Date of Birth of insured** \_\_\_\_\_ **SS# of insured** \_\_\_\_\_

Policy# \_\_\_\_\_ Group# \_\_\_\_\_

Name of 3<sup>rd</sup> insurance Co. \_\_\_\_\_

Name of Person insured \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

**Date of Birth of insured** \_\_\_\_\_ **SS# of insured** \_\_\_\_\_

Policy# \_\_\_\_\_ Group# \_\_\_\_\_

Work information-Employed by: \_\_\_\_\_

Address: \_\_\_\_\_

Phone# \_\_\_\_\_

**Family Physician** \_\_\_\_\_ **Date last seen** \_\_\_ / \_\_\_ / \_\_\_

Address \_\_\_\_\_

Reason for today's doctor visit. \_\_\_\_\_

Allergies(circle if YES): Aspirin Sulfa Penicillin Codeine Demerol Xylocaine Tape Iodine Seafood  
Other allergies \_\_\_\_\_

Patient's Medications \_\_\_\_\_

Previous Surgeries \_\_\_\_\_

Do you smoke? \_\_\_\_\_ Do you drink alcohol? \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_

AIDS/HIV	<input type="checkbox"/> Yes <input type="checkbox"/> No	/ Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	/ Psychiatric Care	<input type="checkbox"/> Yes <input type="checkbox"/> No
Allergies to Anesthetics	<input type="checkbox"/> Yes <input type="checkbox"/> No	/ Ear Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	/ Radiation Treatment	<input type="checkbox"/> Yes <input type="checkbox"/> No
Allergies to Medicine or Drugs	<input type="checkbox"/> Yes <input type="checkbox"/> No	/ Epilepsy	<input type="checkbox"/> Yes <input type="checkbox"/> No	/ Rash	<input type="checkbox"/> Yes <input type="checkbox"/> No
Anemia	<input type="checkbox"/> Yes <input type="checkbox"/> No	/ Eye Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	/ Respiratory Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Angina	<input type="checkbox"/> Yes <input type="checkbox"/> No	/ Fainting	<input type="checkbox"/> Yes <input type="checkbox"/> No	/ Rheumatic Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No
Arthritis	<input type="checkbox"/> Yes <input type="checkbox"/> No	/ Foot or Leg cramps	<input type="checkbox"/> Yes <input type="checkbox"/> No	/ Shortness of Breath	<input type="checkbox"/> Yes <input type="checkbox"/> No
Artificial Heart Valves Or Joints	<input type="checkbox"/> Yes <input type="checkbox"/> No	/ Gout	<input type="checkbox"/> Yes <input type="checkbox"/> No	/ Sinus Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No
Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No	/ Headaches	<input type="checkbox"/> Yes <input type="checkbox"/> No	/ Special Diet	<input type="checkbox"/> Yes <input type="checkbox"/> No
Back Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	/ Heart Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	/ Stroke	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bleeding Disorders	<input type="checkbox"/> Yes <input type="checkbox"/> No	/ Hemophilia	<input type="checkbox"/> Yes <input type="checkbox"/> No	/ Swelling in Ankles or Feet	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No	/ Hepatitis or Jaundice	<input type="checkbox"/> Yes <input type="checkbox"/> No	/ Swollen Neck Glands	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chemical Dependency	<input type="checkbox"/> Yes <input type="checkbox"/> No	/ High Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	/ Tired Feet	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chest Pain	<input type="checkbox"/> Yes <input type="checkbox"/> No	/ Kidney Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	/ Tuberculosis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chronic Diarrhea	<input type="checkbox"/> Yes <input type="checkbox"/> No	/ Liver Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	/ Ulcers, Stomach	<input type="checkbox"/> Yes <input type="checkbox"/> No
Circulatory Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	/ Low Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	/ Varicose Veins	<input type="checkbox"/> Yes <input type="checkbox"/> No
		/ Nervous Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	/ Venereal Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
		/ Phlebitis	<input type="checkbox"/> Yes <input type="checkbox"/> No	/ Weight Loss, Unexplained	<input type="checkbox"/> Yes <input type="checkbox"/> No

Please list any medical conditions not mentioned above \_\_\_\_\_

In order to submit a claim for payment to Dr. Chris Wood/Huntington Foot & Ankle Clinic, Inc. for services covered under your policy, we must have your authorization to release medical information to your insurance carrier.

MEDICARE: I certify that the information given by me is correct. I request payment of authorized Medicare benefits be made to me or on my behalf to Dr. Chris Wood/Huntington Foot & Ankle Clinic, Inc. for any services furnished me by that physician/clinic/supplier. I authorize any holder of hospital or medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine the benefits payable for related services. I understand and agree to pay any charges not paid by Medicare. I permit a copy of this authorization to be used in place of the original.

ALL OTHER INSURANCE: I hereby authorize Dr. Chris Wood/ Huntington Foot & Ankle Clinic, Inc. to submit a claim to my insurance carrier or its intermediaries to issue payment check(s) directly to the organization rendering the services. I authorize Dr. Chris Wood/ Huntington Foot & Ankle Clinic, Inc. to furnish complete information to my insurance carrier or its intermediaries regarding these services.

If you are under the care of another Physician, we may send patient notes and letters concerning your medical condition and treatments to these Physicians.

As a service to our Patients, we will call the phone number you have listed to remind you of your next appointment. If you are not available, we will leave a message about your appointment date and time on your answering machine or with the person who answers the phone.

**I HAVE BEEN NOTIFIED THAT MEDICARE AND MOST OTHER INSURANCES DO NOT PAY FOR THE CUTTING OR TRIMMING OF CORNS OR CALLUSES UNLESS THE PATIENT HAS DIABETES. I AGREE TO BE PERSONALLY AND FULLY RESPONSIBLE FOR THE PAYMENT OF THESE SERVICES.**

**I understand and agree that I am ultimately responsible for the balance of my account (or the account of a minor) for any and all services rendered. My signature below indicates that I have read, understand and agree to the terms printed on this form.**

Signature \_\_\_\_\_ Date \_\_\_\_\_