MASSILLON FOOT AND ANKLE CLINIC

Patient Name _____ Date of Birth_____ Sex___M___F

Social Security #_____ Employed___Y___N Occupation_____

Address_____
Street City State Zip

Home # _____ Work_____ Cell_____

Email_____ **Circle which to use for reminder calls

Emergency Contact _____ Phone # _____

Primary Physician Name _____

Physician Contact Number_____ Date Last Seen _____

How did you hear about us? _____

Insurance Information

Primary Insurance _____ ID# _____ Group#_____

Policy Holders Name_____ Social Security _____

Policy Holders Date of Birth ____/_____/_____ Patients Relationship to Policy Holder _____

Secondary Insurance _____ ID# _____Group#_____

Marital Status (please circle): Married Single Divorced Widowed

May we leave a message in your absence (please circle): Patient Only Spouse Anyone Who Answers

EXPLANATION OF PAYMENT POLICY & PRIVACY POLICY

I hereby authorize Massillon Foot & Ankle Clinic/Dr. Frank Stoddard to release medical information pertinent to the filing of insurance claims for me. I authorize my insurance carrier to pay benefits to Massillon Foot & Ankle Clinic/Dr. Frank Stoddard on any unpaid services filed on my behalf. I understand that I AM RESPONSIBLE for payment to Massillon Foot & Ankle Clinic/Dr. Frank Stoddard for charges for the above patient regardless of my insurance or negotiating settlements of claims. I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have had the opportunity to read and understand the Notice. I also hereby give Massillon Foot & Ankle Clinic/Dr. Frank Stoddard permission to diagnosis and administer treatment for my foot and/or ankle condition and authorize any release of information obtained in the course of my treatment. **I allow Massillon Foot & Ankle Clinic to receive and release my personal and medical information that may be pertaining to my treatment, medical history and also diagnosis.**

Patient Signature: _____ Date: _____

INITIAL HISTORY & PHYSICAL ASSESSMENT

Please fill out as completely as possible. If you have any questions, ask the staff for assistance.

Height _____ Weight _____

Medical History please list all known health related problems…

- ❑ Arthritis
- ❑ Back Problems
- ❑ Blood Disorders
- ❑ Diabetes (Sugar)
- ❑ Difficulty healing
- ❑ Heart Condition
- ❑ HIV/Aids
- ❑ Phlebitis
- ❑ Varicose veins
- ❑ Possibly pregnant
- ❑ Asthma
- ❑ Liver
- ❑ Kidney
- ❑ Lung
- ❑ Skin Disorder
- ❑ Other_____ _____

Review of Systems are you currently experiencing…

- ❑ Difficulty breathing
- ❑ Shortness of breath
- ❑ Chest pain or rapid heart beat
- ❑ Difficulty swallowing
- ❑ Difficulty voiding
- ❑ Change in appetite
- ❑ Unusual aches, pains, cramps
- ❑ Early muscle fatigue
- ❑ Numbness or paralysis
- ❑ Skin problems/ open sores
- ❑ Color changes in feet
- ❑ Poor circulation
- ❑ Morning or night pain
- ❑ Other _____

Medications please list all (including herbs and vitamins) that you are currently taking…

_____ _____ _____ _____

_____ _____ _____ _____

Allergies please include type of reaction…

- ❑ Penicillin
- ❑ Novocaine
- ❑ Aspirin
- ❑ Antibiotics
- ❑ Betadine
- ❑ Tape
- ❑ Cortisone
- ❑ Codeine
- ❑ Shellfish
- ❑ Food
- ❑ Other _____

Surgical History list type of procedure, date of procedure, and any complications…

_____ _____

_____ _____

Social History

Do you smoke? ☐ yes ☐ no Did you smoke in the past? ☐ yes ☐ no

Do you drink alcohol? ☐ yes ☐ no Consumption… ☐ mild ☐ moderate ☐ heavy

Describe your current foot problem:

_____

_____

***** For all patients requesting nail trimming*****. In order for Medicare to cover this particular service, there must be evidence of fungal infection in the nails, and you must indicate they cause you pain or discomfort at some point.

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