KINGS FOOT AND ANKLE CENTER

Patient Information Form (Please Print)

Personal Information

Patient's Name_____Home # _____Cell # _____
Mailing Address_____ City_____ Zip_____
Birth Date_____ Age_____ □Male □Female Social Sec. # _____
Marital Status: □ Single □ Married □ Widowed □ Separated
Spouse/Partner/Parent Name _____Spouse/Partner Parent Date of Birth_____
Employer_____Occupation_____Business Phone _____
E-mail Address (**please print clearly**)_____

Whom May We Contact in the Event of Emergency?

Name_____Relationship_____ Phone #_____

Payment and Insurance Information- Please present your insurance and drivers license upon arrival
□Check if Not Insured
Primary Insurance Co._____ Name of Insured_____
Insured Social Sec. #_____ Insured's Date of Birth_____
Patient's Relationship to Insured: □Self □Spouse □Child □Other
Insured's Employer _____
Secondary Insurance Co. _____Insured_____Insured's Date of Birth_____

According to my insurance, I am responsible to pay a Co-Pay amount $_____
Payment today will be by: □ Cash □ Check □ Visa □ Master card □ HSA/Flex Spending account

Referral Information

Primary Care Physician_____
Address_____ City _____Zip _____
Referred by:
□Doctor _____Address _____City_____ Zip_____
□Patient or Friend (please list) _____
□Preferred Provider (PPO) Directory □Phone Book/Yellow Pages
□Internet_____□ Other (please list)_____

Pharmacy Information

Pharmacy name, location, and phone # _____
_____

Financial Agreement and Authorization for Treatment

I authorize treatment of the person named above and agree to pay all fees and chargers for such treatment. I agree to pay charges for me and members of my family shown by statements, promptly upon presentment thereof, unless credit arrangements are agreed upon in writing. Charges shown by statements are agreed to be correct and reasonable unless protested in writing within thirty days of billing date. In the event that legal action should become necessary to collect an unpaid balance due for medical services rendered to me or my family, I/we agree to pay reasonable attorney's fees or other such costs as the court determines proper. It is agreed that payments will not be delayed or withheld because of any insurance coverage or the pendency of claims thereon, and all proceeds of insurance are assigned to this office where applicable, but without their assuming responsibility for the collection thereof.

AGREEMENT: The above information is for the purpose of obtaining credit and is warranted to be true. I authorize the creditor or his agent to make a credit investigation, including employment verification. A holder of this medical debt contract is prohibited by Section 1785.27 of the Civil Code from furnishing any information related to this debt to a consumer credit reporting agency. In addition to any other penalties allowed by law, if a person knowingly violates that section by furnishing information regarding this debt to a consumer credit reporting agency, the debt shall be void and unenforceable.

ASSIGNMENT OF BENEFITS: I hereby authorize payment directly to Kings Foot and Ankle Center, Inc. of surgical, medical, and x ray benefits otherwise payable to me. I understand I am financially responsible for charges not covered.

There will be a **$30.00** fee for missed appointments without a 24 hour notice, and a **$50.00** for a New Patients.

Signature (patient or guardian) _____ **Date**_____

Acknowledgement of Receipt of Notice of Privacy Practices
Kings Foot & Ankle Center, Inc.
806 W. Seventh Street
Hanford, CA 93230
(559) 584-5196

I hereby acknowledge that I received and/or was given the opportunity to receive a copy of this medical practice's Notice of Privacy Practices. I further acknowledge that a copy of the current notice will be posted in the reception area and I will be offered a copy of any amended Notice of Privacy Practices at each appointment.

Signed: _____ Date: _____

Print Name: _____ Telephone: _____

If not signed by the patient, please indicate:

Relationship:

- ☐ Parent or guardian of minor patient
- ☐ Guardian or conservator of an incompetent patient
- ☐ Beneficiary or personal representative of deceased patient

Name of Patient: _____

KINGS FOOT AND ANKLE CENTER

MEDICAL HISTORY FORM (Please fill out completely)

YOUR NAME_____ **DATE OF BIRTH**_____

REASON FOR SEEING DOCTOR TODAY_____

PAIN INTENSITY: RATE 0 TO 10_____

CURRENT MEDICATIONS_____

ALLERGIES: Are you allergic to any medications? ☐ No ☐ Yes (please specify below)_____

LIST ANY TIME YOU HAVE STAYED IN A HOSPITAL AND ALSO ANY OPERATIONS PERFORMED ON YOU_____

WHAT MEDICAL CONDITIONS DO YOU SEE A DOCTOR FOR OR TAKE MEDICATIONS TO TREAT? _____

FAMILY MEDICAL HISTORY (briefly, what medical problems run in the family)? _____

PREVIOUS HISTORY OF FOOT, ANKLE, OR LEG PROBLEMS_____

SMOKING/TOBACCO ☐ No ☐ Yes_____Pack/day

ALCOHOL INTAKE_____

WORK DESCRIPTION_____

RECREATIONAL ACTIVITY_____

LIVING SITUATION (alone, or with assistance?)_____

Do you have an Advance Directive? _____ Living will? _____

SHOE SIZE_____ **APPROXIMATE HEIGHT** _____ **WEIGHT**_____

I certify by my signature that the above noted medical history is complete, accurate, and current to the best of my knowledge.

Signature of Patient/Guardian: _____ Date: _____ Physician Initial: _____

KINGS FOOT AND ANKLE CENTER

REVIEW OF MEDICAL PROBLEMS PAST OR PRESENT

For all items below, please mark Yes (Y), No (N), OR (?) if unsure

YOUR NAME_____ **DATE OF BIRTH**_____

	Heart/Circulation	Comments
	Chest Pain/ Tightness	
	Heart Attack	
	Heart Surgery	
	Congestive Heart failure	
	Heart Valve Disease/murmur	
	Pacemaker/ Heart implant	
	High blood pressure	
	High cholesterol	
	Stroke/ TIA	
	Blood vessel surgery	
	Blood clots/ bleeding problems	
	Lungs	
	Difficulty breathing/ asthma	
	Shortness of breath	
	Coughing up blood	
	Current/frequent cough	
	Sleep apnea/heavy snoring	
	Nervous System	
	Fainting/blackouts	
	Seizures	
	Abnormal feeling	
	Rheumatic Disease	
	Skin	
	Sores/ Rashes	
	Sensitivity/ Allergy	
	Genital/ Urinary	
	Dialysis	
	Kidney Disease	
	Gynecologic	
	Pregnant or possibly pregnant	
	Breastfeeding	
	Last menstrual date	
	Walking/ balancing problems	
	History of falls	

	Endocrine	Comments
	Thyroid disease	
	Diabetes	
	Other	
	Blood	
	Anemia	
	Infectious Disease	
	HIV	
	Hepatitis	
	Stomach/ Abdomen	
	Indigestion, reflux	
	Liver disease	
	Ulcers, hernias	
	Bloody/dark stool	
	Bones/ Joints/Muscles	
	Pain	
	Arthritis	
	Cane, brace, etc.	
	Joint replacement	
	Back or Neck Pain	
	Injuries	
	Constitutional	
	Current fever/chills/nausea	
	Unexplained weight loss	
	Pain intensity 1-10	
	Ears/Nose/ Throat	
	Any current problems	
	Psychiatric	
	Depression, Anxiety, Other	
	Cancer	
	Current or past	
	Radiation	
	Chemotherapy	
	Type and Location	
	Miscellaneous	

I certify by my signature that the above noted medical history is complete, accurate, and current to the best of m knowledge.

Signature of Patient/Guardian:_____ Date:_____ Physician Initial:_____

Name_____ Date_____

Do I Need a Test For PAD?

Peripheral Artery Disease (PAD) is a serious circulatory problem in which the blood vessels that carry blood to your arms, legs, brain and kidneys, become narrowed or clogged. It affects approximately 20 million Americans, most over the age of 50. It may result in leg discomfort with walking, poor healing of leg sores/ulcers, blood pressure that is difficult to control, or symptoms of stroke. People with PAD are at significantly higher risk of stroke and heart attack. Answers to these questions will help determine if you are at risk for PAD and if a vascular exam will help us better assess your vascular health status.

		CHECK YES	CHECK NO
1.	Do you have foot, calf, buttock, hip or thigh discomfort (aching, fatigue, tingling, cramping or pain) when you walk which is relieved by rest?	☐	☐
2.	Do you have a history of cardiovascular disease or diabetes and experience any pain or swelling at rest in your lower legs or feet?	☐	☐
3.	Do you have a history of cardiovascular disease or diabetes and experience any leg, foot, or toe pain that often disturbs your sleep?	☐	☐
4.	Do you have an ulcer on your thigh, calf, ankle, foot or toe that is slow to heal?	☐	☐
5.	Do you have diabetes and unusual hair loss or skin discoloration in your legs?	☐	☐
6.	Do your fingers or toes feel numb or cold in response to temperature changes or stress?	☐	☐
7.	Have you suffered a severe injury to your leg(s) or feet?	☐	☐
8.	Do you have an infection of the leg(s) or feet that may be gangrenous (black skin tissue)?	☐	☐
9.	Have you had blockages in your coronary or heart arteries?	☐	☐

Other Comments or Notes: _____

_____

_____

Patient Signature:_____ Date:_____