



Patient Information

Patient Name: _____ SSN: _____ - _____ - _____

Date of Birth: _____

Home Address: _____

City _____ ZIP: _____

Home # _____ Cell # _____ Work# _____

E-Mail Address _____

Emergency Contact: _____ Phone Number _____

Primary Physician: _____ Phone Number _____

Referring Physician: _____ Phone Number _____

Pharmacy Info. _____ Phone Number _____

Sex: Male or Female

Chief Complaint: _____

Signature of Patient or Guardian if Patient is a Minor

Date

FILL OUT IF INFORMATION IS DIFFERENT THAN PATIENT

Guarantor Name: _____

SSN# _____ - _____ - _____ Date of Birth: _____

I understand and agree that (regardless of my insurance), I am ultimately responsible for the balance of my account for any professional services rendered. I have read all the information on both sides of this sheet and have completed the above answers. I certify this information is true and correct to the best of my knowledge I will notify you of any changes in my status or the above information.

Crown Foot and Ankle Center

Past Medical History/Medical Problems

Full Name: _____

Date: _____

Chief Complaint/Reason for visit today: _____

Height: _____ Weight: _____

Please check all that apply:

- | | | |
|--|---|---|
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Diabetes/High Sugar | <input type="checkbox"/> High Cholesterol/Lipids |
| <input type="checkbox"/> Arthritis (DJD, Osteoarthritis) | Insulin? <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Joint replacements |
| <input type="checkbox"/> Arthritis (Rheumatoid) | <input type="checkbox"/> Emphysema/COPD | <input type="checkbox"/> Kidney Disease |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Gastric Bypass Surgery | <input type="checkbox"/> Liver Disease/Cirrhosis |
| <input type="checkbox"/> Atrial Fibrillation (AFIB) | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Mental/Mood Disorder |
| <input type="checkbox"/> Back Pain/Disc Disease | <input type="checkbox"/> Gout | <input type="checkbox"/> Osteoporosis/Weak Bones |
| <input type="checkbox"/> Blood Clots/Pulmonary Embolism | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Seizure Disorder |
| <input type="checkbox"/> Cancer: _____ | <input type="checkbox"/> Heart Disease/Stents | <input type="checkbox"/> Stomach Ulcer/Bleed/GERD |
| <input type="checkbox"/> Crohn's Disease/IBS | <input type="checkbox"/> Hepatitis B/C | <input type="checkbox"/> Stroke/CVA/TIA |
| <input type="checkbox"/> Depression | <input type="checkbox"/> HIV | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Dialysis | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Vision Problems/Glasses |

Family History:

- | | | | | |
|--|-----------------------------------|--|------------------------------------|--------------------------------------|
| <input type="checkbox"/> Mother: | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Father: | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Siblings | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Grandparents: | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Other _____ |

Race: _____

Ethnicity: _____

Single Married Divorced

Widowed

Do you live in a nursing home? Yes No

Do you live alone? Yes No

Do you Smoke? Yes No

Home Health Services? Yes No

If Yes, How many years? _____

Packs/Day _____

Do you drink alcohol? Yes No

Occupation: _____

If Yes, # Per Week: _____

Rate Pain by circling number: 10 9 8 7 6 5 4 3 2 1 0 (10 being the worst)

How long has condition been present? _____

Did the condition start suddenly/gradually? _____

History of injury related to condition? _____

What part of Foot is pain present? _____

Anything make it better/worse? _____

Any Previous treatments? _____

Please list ALL surgeries and Dates: _____

Date of last FLU Vaccine: _____

CROWN

FOOT AND ANKLE CENTER

500 Southland Dr.
Lexington KY, 40503
Phone: 859-236-3142 Fax: 859-317-9518

PATIENT NAME: _____

DOB: _____

PROVIDER / PRACTICE NAME

I do hereby consent and authorize you to release copies of my medical records, including current and previous medical records from other practices and practitioners, hospitals and/or clinics which are a part of my medical records. I agree that a copy of this release or a fax of this release shall be as valid as this original release.

Please send copies of requested information as soon as possible to the address listed at the top of this request.

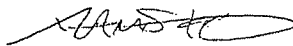
ALL RECORDS: _____

RECORDS From: _____ To: _____

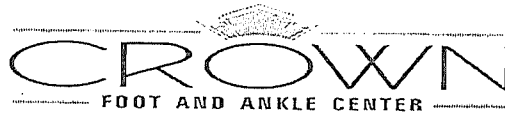
Include:
Patient Histories _____ Office Notes _____ Psychotherapy Notes _____ Test Results _____
Radiology Studies Films _____ Referrals Consults _____ Billing Records _____ Insurance Records _____
Records by Other Health Care Providers _____ Alcohol/Drug Treatment _____ HIV-Related Information _____
Mental Health Information _____
OTHER: _____

Patient/Guardian Signature _____ Witness _____

Thank You,
Thomas King, DPM, FAC, FAS



Electronically Signed



SUMMARY OF NOTICE OF PRIVACY PRACTICES

PATIENT NAME: _____

This summary is provided to assist you in understanding Privacy Practice.

The Notice of Privacy Practices contains a detailed description of how our office will protect your health information, your rights as a patient and our common practices in dealing with patient health information. Please refer to that Notice for further information.

Uses and Disclosures of Health Information. We will use and disclose your health information in order to treat you or assist other health care providers in treating you. We will also use and disclose your health information in order to obtain payment for our services or to allow insurance companies to process insurance claims for services rendered to you by us or other health care providers. Finally, we may disclose your health information for certain limited operational activities such as quality assessment, licensing, accreditation and training of students.

Uses and Disclosures Based on Your Authorization. Except as stated in more detail in the Notice of Privacy Practices, we will not use or disclose your health information without your written authorization.

Uses and Disclosures Not Requiring Your Authorizations. In the following circumstances, we may disclose your information without your written authorization.

- To family members or close friends involved in your health care.
- For certain limited research purposes.
- For purposes of public health and safety.
- To government agencies for purposes of their audits and investigations.
- To government authorities to prevent child abuse or domestic abuse.
- To the FDA to report products defects or incidents.
- To law enforcement authorities to protect public safety or to assist in apprehending criminal offenders.
- When required by court orders, search warrants, subpoenas and as otherwise required by law.

Patient Rights. As our patient, you have the following rights:

- To have access to and/ or a copy of your health information.
- To receive an accounting of certain disclosures we have made of your health information.
- To request restrictions as to how your health information is used or disclosed.
- To request that we communicate with you in confidence.
- To request that we amend your health information.
- To receive notice of our practices.

If you have a question, concern or complaint regarding our privacy practices, please contact Crown Foot and Ankle Center, 500 Southland DR, Lexington, KY 40503, or call 859-317-9019/ fax 859-317-9518.

FINANCIAL POLICY

Welcome to Crown Foot and Ankle. We are glad you've chosen us to provide you with your healthcare. We are a professional service organization that is dedicated to the practice of medicine, specializing in podiatry. The mission of our practice is to provide high quality medical care at a fair and reasonable cost to those in the area. We charge what are usual and customary fees in our area.

Your insurance policy is a contract between you and your insurance company. Please understand our office cannot accept responsibility for collecting your insurance claim or negotiating a settlement on a disputed claim. Whatever the outcome of your insurance claim, you are responsible for payment of your account. Past-due accounts are an extra cost in operating an office. Our costs, and therefore your costs, are substantially increased when bills are not paid promptly.

The following is a statement of our Financial Policy, which we require that you read and sign prior to treatment.

**FULL PAYMENT IS DUE AT THE TIME OF SERVICE
WE ACCEPT CASH, CHECKS, CREDIT CARDS AND MONEYORDERS
WE OFFER AN EXTENDED PAYMENT PLAN WITH PRIOR APPROVAL**

An exception to the above is the select insurance companies we will bill directly or health maintenance organizations and preferred provider organizations we participate in. If we are a participating provider for your insurance company we will submit your claim directly to your managed care insurer. Co-payments, if any, will be collected at the time of your visit. Please be aware there is a possibility that some and perhaps all of the services provided may be non-covered services and not considered reasonable and necessary under your medical insurance. If you receive a service your insurance does not cover or if you have a deductible you have not met, we will request payment in full from you at the time you receive the service. Some insurance companies require a Precertification with the insurance company prior to our doctors treating you. Please check your policy for this requirement.

Extended Payment Plan

We also understand that financial problems arise from time to time. Please let us know if you need to arrange a payment plan that allows you to pay off your balance in monthly installments. Our office manager can assist you with these arrangements.

Thank you for reading and understanding our Financial Policy. Please let us know if you have any questions or concerns.

I have read, understand and agree to this Financial Policy.

Signature of Patient/Guardian (If Patient is a Minor)

Date