CROWN
FOOT AND ANKLE CENTER

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:

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

Family History:

☐Mother:	☐Diabetes	☐Heart Disease	☐Arthritis	☐Other _____
☐Father:	☐Diabetes	☐Heart Disease	☐Arthritis	☐Other _____
☐Siblings	☐Diabetes	☐Heart Disease	☐Arthritis	☐Other _____
☐Grandparents:	☐Diabetes	☐Heart Disease	☐Arthritis	☐Other _____

Race:_____
Ethnicity:_____
☐Single ☐Married ☐Divorced ☐Widowed

Do you live in a nursing home? ☐Yes ☐No
Do you live alone? ☐Yes ☐No
Home Health Services? ☐Yes ☐No

Do you Smoke? ☐Yes ☐No
If Yes, How many years? _____ # Packs/Day _____
Do you drink alcohol? ☐Yes ☐No
If Yes, # Per Week: _____
Occupation: _____

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: _____

Medication List

List **ALL** Medications you are currently taking (Including Vitamins and Supplements)

IF YOU HAVE A LIST OF MEDICATIONS, PLEASE PROVIDE

Medication	Dose	Frequency

Pharmacy: _____ **Phone:** _____

Primary Care provider: _____ **Phone number:** _____

Drug Allergies: _____

Other Allergies: _____

Patient Name: _____

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

CROWN
FOOT AND ANKLE CENTER

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**