

Coastal Foot & Ankle Wellness Center * New Patient Info & Chart Update
Please Complete ALL Sections – Thank You - (Please Print)

Date: _____ Sex: M___ F___ DOB: _____ Email: _____

Last Name: _____ First Name: _____ Middle Initial: _____

Street Address: _____ City: _____ State: _____ Zip: _____

Home Ph#: (____) _____ Cell#: _____ Are You Active Military? _____

Employer Name: _____ Employer Ph#: _____

Occupation: _____ Full or Part-Time? _____

Marital Status: ___ Married ___ Single ___ Divorced ___ Widowed ___ Other

Primary Language Spoken: _____ When is the last time you saw a podiatrist? _____

Race: ___ White/Caucasian ___ Black/African-American ___ Other

Ethnicity: ___ Spanish ___ Asian ___ Other

Name and DOB of Insurance Policy Holder if Other than Patient: _____/_____

How Did You Hear About Our Office? _____

What Problem Brings You to the Office Today? _____

Is Your Visit AUTO Accident or WORKCOMP related? (Circle One): YES / NO

What is the Name of Your Primary Care Physician? _____

Do you have an Endocrinologist? If yes, what is his/her name? _____
(Doctor who treats your diabetes)

Whom May We Contact In Case of Emergency?

Name: _____ Ph#: _____ Relationship: _____

Parent/Guardian Name (for patients under the age of 18): _____

(*Please Note: If patient is a minor, we need the guardian's employment information completed above)

Parent/Guardian DOB: _____

Financial Policy for Coastal Foot & Ankle Wellness Center

All professional services rendered are charged to the patient, who is responsible for all fees, regardless of insurance coverage. Please read the following policies and ask about any questions that you may have prior to signing.

1. I hereby authorize Coastal Foot & Ankle and Wellness Center to furnish information concerning my illness and treatments to my insurance carrier(s) on my behalf.
2. I authorize the use of this form, or a copy of it, to be used on all my insurance submissions, and I authorize payment to be sent directly to Coastal Foot & Ankle.
3. If, for any reason, my insurance company denies payment-- due to deductibles or non-covered services-- I will be responsible for the amount charged by the physician for his/her services at the time of the visit.
4. If my account should fall delinquent, I understand that I will be responsible for payment of all collection costs and all legal fees.

Signature: _____ **Date:** _____

**** COPAYMENTS ****

If your insurance has an assigned COPAY, that copay must be paid at the time of service for each applicable office visit. Please Note: We are considered a Specialist Office.

Types of Payments Accepted

* CASH * CREDIT/Debit CARD: Visa/Mastercard * CHECK * MONEY ORDER

IMPORTANT NOTICE:

To comply with the Federal Anti -ID -Theft Laws, we are required to scan and keep a photocopy of your driver's license or alternate government-issued photo ID as well as a copy of your insurance card(s).

New patients who present without a valid photo ID cannot be seen until such ID can be presented. ~ Thank You!

Please Note: We encourage patients to sign up for our secure Coastal Patient Portal for access to all patient notes and for additional communication with the office. -- All patients have the right to a summary printout of their visit. If you elect not to sign up for the patient portal and if you would like a copy of your visit summary before you leave, please inform the front desk and one will be printed for you.

Coastal Foot & Ankle Wellness Center
PAST and PRESENT Patient Medical History (Please Print)

PATIENT NAME: _____ **/ DOB:** _____

Are You Diabetic? YES / NO **If yes, are you insulin dependent?** YES / NO

MEDICATION Allergies: _____

____ No Known Drug Allergies ____ Allergic to Latex ____ Allergic to Tape

FOOD Allergies: _____

CURRENT MEDICATIONS

**** Please sign your name on the line below if you consent to our physicians obtaining your prescription information from the pharmacy database. Information received is for patient care only and the information retrieved will become a part of your HIPAA protected chart.**

Patient Signature: _____

Check here ____ if you do **NOT** authorize us to obtain a list of medications from the pharmacy database.

***** (Please Note: In order to protect your health from potential contraindicated medication complications, our physicians will not be able to write any prescription for any patient who has not given consent to obtain a full Rx medication list)*****

Medication _____	Frequency _____	Mg _____
Medication _____	Frequency _____	Mg _____
Medication _____	Frequency _____	Mg _____

What is Your Preferred Pharmacy? _____ **Street or Location:** _____

FALL RISK: Have you fallen within the last six months? Y / N – If yes, how many times? _____

SMOKING

Do You Smoke? YES / NO If yes, how many packs per day? _____ # of Years? _____

How soon after you wake up do you smoke? _____ Are you interested in quitting? YES / NO

DRUG USE: Do you take illegal drugs or illegal Rx medications? YES / NO

ALCOHOL: Do you drink alcohol? YES / NO If yes, how many drinks on a typical day? _____

How often did you have a drink with alcohol in it over the last year? _____

Are you interested in quitting? YES / NO

Coastal Foot & Ankle Wellness Center
PAST and PRESENT Patient Medical History - Continued

PATIENT NAME: _____ **/ DOB:** _____

Do You Have METAL in Your Body? YES / NO If yes, where? _____

FAMILY HISTORY (circle all that apply)

Mother:	Heart Attack	Stroke	Diabetes
Father:	Heart Attack	Stroke	Diabetes
Grandparent:	Heart Attack	Stroke	Diabetes

PAST or PRESENT Illnesses (Please circle all that apply)

Asthma Emphysema Cancer (Type) : _____ Liver Disease
Hypothyroid Hyperthyroid GERD Sleep Apnea High Blood Pressure DVT
High Cholesterol Peripheral Vascular Disease Coronary Artery Disease Arrhythmias
AFIB Osteoarthritis Heart Attack (What Age?) _____ Stroke (What Age?) _____
Macular Degeneration Blindness Hearing Loss Deafness Hepatitis HIV/Aids
Polio Tuberculosis Anxiety Depression Nervousness Bipolar Disorder OCD
ADHD Schizophrenia Murmur Anemia Clotting Problem Mitral Valve Prolapse
Circulator Problems Abdominal/Aortic Aneurysm High Cholesterol Low Cholesterol
High Triglycerides Low Triglycerides COPD Eczema Psoriasis Neuropathy
Epilepsy Alzheimers Parkinsons Aneurysm Multiple Sclerosis Fibromyalgia
Rheumatoid Arthritis Osteoporosis Other: _____

PAST SURGERIES / PROCEDURES: (Please circle all that apply)

Appendectomy Back Heart Bypass Gallbladder Hernia Hip Hysterectomy

Foot Ankle Intestinal Leg Stents Joint Replacement (What joint? _____)

Please list anything regarding your foot / leg health (past or present) that you feel would be beneficial for the doctors to know:



CANCELLATION and NO SHOW POLICY

Our goal is to provide quality individualized medical care to all of our patients. Late cancellations and 'no shows' create inconvenience to other patients who are in need of medical treatment and who could have benefited from your unused appointment time.

In order to be respectful of the needs of all of our patients, we require at least 24 hours advance notice for any cancellation. Appointments are often in high-demand and your prompt cancellation will give another patient the possibility to receive care in an expedited manner.

Office appointments which are cancelled with less than 24 hours advanced notification may be subject to a non-refundable **\$20.00** administrative fee. Patients who do not call and do not show up for their appointment may also be subject to the **\$20.00** administrative fee.

Due to limited schedule availability for surgical cases, scheduled office surgeries require at least a 5 (five) business day advanced cancellation notice. Patients who do not cancel their procedure within the required time frame or who No Show for their office surgery may be subject to a **\$75.00** Surgery No Show Fee.

Please note that Cancellation and No Show fees are the sole responsibility of the patient. This will not be billed to or covered by your insurance. Payment of fee will be due prior to scheduling your next appointment.

We understand that special, unavoidable circumstances may cause you to not be able to cancel within the required 24 hours for office appointment or 5 business days for surgery. Fees in this instance may be waived but would require approval and written waiver from management.

If you have any questions regarding this policy, please feel free to ask for clarification from staff or management. We thank you in advance for your cooperation and understanding.

I acknowledge that I have read and understand the Coastal Appointment Cancellation and No Show policy.

Patient Name (please print): _____ Date: _____

Patient Signature: _____

Coastal Foot & Ankle Wellness Center

Notice of Privacy Practice Acknowledgement

I understand that, under the Health Insurance Portability & Accountability act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- * Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly or indirectly.
- * Obtain payment from third party payers.
- * Conduct normal healthcare operations such as quality assessment and physician certifications.

I have received and/or read and understand the Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that Coastal Foot & Ankle Wellness Center has the right to change it's Notice of Privacy Practices from time to time and that I may contact Coastal at any time to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand that that Coastal Foot & Ankle is not required to agree to my requested restrictions, but if agreement is made, they are bound to abide by such restrictions.

Patient Name: (please print) _____

Parent/Guardian (if patient is a minor) _____

I hereby give consent and authorize Coastal Foot & Ankle Wellness Center to allow the person(s) listed below to have access to my account information, including communication with the office staff/doctors on my behalf.

_____ / Relationship: _____

_____ / Relationship: _____

_____ / Relationship: _____

I choose NOT to authorize any individual (including family) to have access to my account. (Please check)

Patient Signature: _____ / Date: _____