Foot and Ankle Clinics, P.A.

Jeff C Pollersels, DPM, FACFAS, Diplomat of the American Board of Podiatric Surgery

Sports Medicine – Surgery – Othotics – Diabetic Foot Care – Laser – Pediatrics – General Foot Care

Name: ____ **Date of Birth:** ___/___/___
(First) (Middle Initial) (Last)

Address: ____
(Street) (City) (Zip Code)

Home Phone: (____) __________ **Cell Phone:** (____) __________ **Email:** __________

Height: _____ **Weight:** _____ **Shoe Size:** _____ **Marital Status:** M P S D W

Emergency Contact: ____
(Name) (Phone Number)

Race/Ethnicity: (Please Check All That Apply)

[] American Indian/Alaskan Native [] Asian [] White/Caucasian
[] Black/African American [] Native Hawaiian [] Hispanic/Latino

Pharmacy Name and Phone Number: ______________________________

Primary Care Physician/Clinic: ______________________________

Date of Last Physical Exam: ______________________________

Referring Physician: ______________________________

Patient's Occupation/Employer: ______________________________

Insurance Policy Holder's Name: ______________________ **Policy Holder's Date of Birth:** ___/___/___

Have you had any injuries to your feet, ankles, legs, or back? If yes, what injuries have you had?

____

Do you have any allergies to medications, adhesives, wool, or other? [] Y [] N
If yes, list here: ______________________________

Are you currently taking any medications: [] Y [] N If yes, what are you taking?

____

Do you smoke [] Y [] N If yes, how many packs per day? _____ Are you a former smoker? [] Y [] N

Have you ever been treated for any of the following diseases? (Check all that apply)

[] Heart Trouble [] High Blood Pressure [] Diabetes
[] Epilepsy [] Rheumatic Fever [] Tuberculosis
[] Liver Problems [] Kidney Problems [] Stroke

Assignment of Benefits: I authorize all medical benefits to be directly paid to Foot and Ankle Clinic, P.A. I hereby authorize Foot and Ankle Clinics to release to my insurance company, health plan, HMO, no fault carrier and/or worker's compensation carrier my complete health record needed to determine benefits for services provided by Foot and Ankle Clinic, P.A. I am responsible for all services paid by the insurance company. Should I become delinquent I agree to pay collection costs, attorney's fee, interest, and any costs associated with my account being placed in collections and/or attorney litigation. I authorize Foot and Ankle Clinics to release information to my Primary Care Physician

Signature: ____ **Date:** ___/___/___

Medicare Patients: I request payment of Medicare payments be made directly to the Foot and Ankle Clinic for any services furnished to me by the organization. I authorize the release of information about my care to HCFA and its agents.

Signature: ____ **Date:** ___/___/___