

"EXPECT THE BEST"

PATIENT INFORMATION

Please Print Clearly

Patient Name: _____ Sex: _____ Age: _____

Guardian/ Parent/ Contact (if applicable) _____ Ph# _____

Birth Date: _____ SSN : _____ Shoe Size: _____ Weight: _____ Height: _____

Race: _____ Ethnicity: _____ Primary Language: _____

Patient Address: _____ City, State, Zip _____

Home#: _____ Cell#: _____ Work# _____

Occupation: _____ Employer: _____

GUARANTOR INFORMATION (Person who holds the insurance policy)

Name: _____ Sex: _____ Age: _____

Address City, State, Zip: _____

Ph#: _____ Wk#: _____ Birth Date: _____ SSN: _____

Whom may we thank for referring you to us? _____

REASON FOR VISIT

How do you describe you foot/ankle problems? _____ How long? _____

What treatments, both at home and professional have you tried? _____

Have any of the above treatments helped at all? _____

Are your injuries accident related? Y N Did your injuries occur at work? Y N

DRUG ALLERGIES: _____

MEDICAL HISTORY (Patient)

Medicines you currently take: _____

Surgeries and years performed: _____

() Diabetes **If yes** do you take insulin? () Yes () No Average Blood Sugar: _____

() Heart Disease () Hepatitis(A,B,C) () Tuberculosis () Blood Thinners () Hypertension

() Arthritis () HIV (AIDS) () Kidney Problems () Sickle Cell Anemia () Bleeding Disorder

() Liver Problems () Phlebitis () Gout () Cancer () Stomach Ulcer

() Varicose Veins () Poor Circulation () Prone to Infection () Unequal Leg Length () Lower Back Problem

Do you have any trouble taking Aspirin products? () Yes () No

Tobacco (packs per day): _____ Alcohol (amount per day): _____

FAMILY HISTORY (Immediate only)

- () Diabetes () Heart Disease () Hypertension () Flat Feet () Arthritis
- () Tuberculosis () Cancer () Bunions () Hammertoes () Gout

EMERGENCY CONTACT INFORMATION

Name: _____ Ph#: _____ Relationship: _____

Address: _____

City, State, Zip: _____

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage with _____ and assigns to Dr. Stran all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for costs not covered or reimbursed by third party payers. I hereby authorize the doctor to release all information, including information which may be considered a communicable or venereal disease, including hepatitis, syphilis, gonorrhea, HIV, AIDS, necessary to secure the payment of benefits to any responsible party. I authorize the use of this signature on all insurance submissions certifying that the information provided here is true and correct.

Patient's Signature (or Legal Guardian)

CONSENT TO TREAT

I request and authorize the physician and his staff to provide me with treatment, and to perform any procedures now contemplated or such additional procedures as my doctor may deem reasonable and necessary. I authorize the Social Security Administration to disclose information regarding my Medicare coverage. The undersigned certifies that he/she has read the foregoing and is the patient, or is duly authorized by that patient as patient's general agent to execute the above and accept the terms. It is further understood that this release remains in effect for as long as I am a patient of Dr. Stran unless otherwise revoked.

Patient's Signature (or Legal Guardian)

HIPPA STATEMENT

I Acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read if I so choose) and understood the Notice.

Patient's Signature (or Legal Guardian)

FINANCIAL RESPONSIBILITY

I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance of my account for any professional services rendered. 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.

Patient's Signature (or Legal Guardian)