Gregory A. King, D.P.M.

Foot & Ankle Specialist

Today's Date:

Name: _____ DOB: _____ Age:_____

Sex: ☐ M ☐ F Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced SS#: _____

E-mail: _____ Spouse/Partner Name: _____

E-mail newsletters, reminders, statements, etc.

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

Home #: _____ Cell#: _____ Other #: _____

Employer: _____ Phone: _____

Employer Address: _____ City: _____ State: _____ Zip: _____

Pharmacy Name: _____

Pharmacy Address: _____

Primary Care Physician: _____ Phone: _____ Date Last Seen: _____

Address: _____

Referring Physician: _____ Phone: _____ Date Last Seen: _____

Address: _____

IT'S OFFICE POLICY NO DOGS ARE PERMITTED IN THE OFFICE EXCEPT FOR THE DOGS THAT ARE CERTIFIED SERVICE DOGS.

What is the reason for your visit today?

How long has this bothered you? ◯ 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5 ◯ 6 ◯ 7 ☐ days ☐ weeks ☐ months ☐ years

What treatments have you tried & have they been effective?

On a scale of 1-10 (I being no pain and 10 being the worst) what is your level of pain? _____/10

The pain quality is: ☐ burning ☐ constant ☐ dull ☐ sharp ☐ shooting ☐ throbbing ☐ tingling Other: _____

Medical History:

- ☐ Alcoholism
- ☐ Blood disorders
- ☐ Circulation problems
- ☐ Muscoloskeletal
- ☐ Breathing issues
- ☐ Liver
- ☐ Sleep apnea
- ☐ Gout
- ☐ Allergies
- ☐ Heart disease
- ☐ Asthma
- ☐ Heart murmur
- ☐ Stomach/bowel
- ☐ Depression
- ☐ Anxiety disorder
- ☐ Mental illness
- ☐ Kidney disease
- ☐ Blood clot
- ☐ High cholesterol
- ☐ High blood pressure
- ☐ Cancer
- ☐ Hepatitis
- ☐ Neuropathy (specify) _____
- ☐ Thyroid disease (specify) _____
- ☐ Diabetes (type1, type 2)
- ☐ Arthritis (specify) _____
- ☐ other (specify) _____
- ☐ HIV
- ☐ CVA
- ☐ Skin disorders
- ☐ Stroke

Are you pregnant? ☐ Yes ☐ No **Are you nursing?** ☐ Yes ☐ No

Surgical History ☐ None ☐ Appendectomy ☐ C-Section ☐ Angioplasty ☐ Bypass ☐ Cataracts ☐ Cholecystectomy

Have you ever had any surgical procedures on foot/ankle or anywhere else on your body? ☐ Yes ☐ No

If yes, please describe: _____

Do you have any artificial joints? ☐ Yes (where? _____) ☐ No Do you have an artificial heart valve? ☐ Yes ☐ No

Social History

Do you smoke? ☐ Yes ☐ No, If yes how many packs per day? ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 For how long?

Do you drink alcohol? ☐ Yes, everyday (5-7 days/week) ☐ Yes, occasionally/socially ☐ No/Rarely

Substance abuse: ☐ Yes, I have a current substance abuse problem. Please specify: _____

☐ Yes, I had a past substance abuse problem. Please specify: _____

☐ No, I have never had a substance abuse problem

What is your occupation? _____ Does it involve mostly ☐ standing or ☐ sitting

Do you exercise regularly? ☐ No, I do not exercise regularly ☐ Yes, I do the following regular exercise: _____

Family History Is there any family history (blood relative) of: (Please indicate family member)

- ☐ Alzheimer's _____
- ☐ Arthritis _____
- ☐ Bleeding disorders _____
- ☐ Blood clot _____
- ☐ Cancer _____
- ☐ Cataracts _____
- ☐ Circulation problems _____
- ☐ Other (specify): _____
- ☐ Depression _____
- ☐ Diabetes _____
- ☐ Emphysema _____
- ☐ Heart disease _____
- ☐ High Blood Pressure _____
- ☐ Neurological _____
- ☐ Strokes _____

PLEASE READ AND SIGN

The above information is correct to the best of my knowledge. I understand that throughout my treatment, I am responsible for notifying the physician and/or medical staff of any and all updates to the information listed above.

Patient Signature: _____ Date: _____

Name: _____

Review of Systems *(Please check the box if you currently have any of these symptoms or check "NONE")*

Cardiovascular	☐ leg pain when walking	☐ fever	☐ chest pain/pressure	☐ leg swelling	☐ cold hands/feet
	☐ fainting	☐ palpitations	☐ vascular disease	☐ valve problems	☐ **NONE**
Genitourinary	☐ blood in urine	☐ hesitancy	☐ incontinence	☐ increased urgency	☐ **NONE**
	☐ decreased frequency	☐ exercise urination	☐ kidney disease	☐ kidney stones	
Gastrointestinal	☐ abdominal pain	☐ heartburn	☐ blood in stool ☐ vomiting	☐ ulcers	☐ constipation
	☐ diarrhea	☐ trouble swallowing	☐ decrease appetite	☐ increase appetite	☐ **NONE**
Integumentary	☐ athletes foot ☐ nail abnormalities ☐ keloids		☐ itchiness	☐ dry, scaly skin	☐ **NONE**
Hematologic	☐ lower leg ulcers ☐ sickle cell disease ☐ anemia		☐ blood thinners	☐ clotting disorders	☐ **NONE**
Neurological	☐ tingling	☐ weakness	☐ seizures	☐ numbness	☐ headaches
	☐ tremors	☐ paralysis			☐ **NONE**
Musculoskeletal	☐ back pain	☐ joint swelling	☐ muscle weakness	☐ muscle pain	☐ neck pain
	☐ sciatica	☐ joint stiffness	☐ joint pain	☐ arthritis	☐ **NONE**
Respiratory	☐ chest pain	☐ wheezing	☐ COPD	☐ coughing	☐ snoring
	☐ shortness of breath	☐ emphysema			☐ **NONE**

Smoking Status

☐ Current Every Day Smoker ☐ Never Smoker
☐ Current Some Day Smoker ☐ I decline to answer
☐ Former Smoker

Vital Signs

Blood Pressure: _____/_____
Height: _____ Weight: _____

Current Medications

☐ No Known Medications
☐ I have a list of medications (Please give to office staff)
☐ I take the following prescriptions/over the counter medications:

Name: _____ Dose _____
Name: _____ Dose _____
Name: _____ Dose _____
Name: _____ Dose _____
Name: _____ Dose _____
Name: _____ Dose _____
Name: _____ Dose _____
Name: _____ Dose _____
Name: _____ Dose _____
Name: _____ Dose _____
Name: _____ Dose _____

Use the back of this form if more room is needed

Allergies

☐ **No Known Allergies**

	Reaction
☐ Penicillin	_____
☐ Shellfish	_____
☐ Sulfa	_____
☐ Tape	_____
☐ Latex	_____
☐ Betadine (iodine)	_____
☐ Aspirin	_____
☐ Tylenol	_____
☐ Ibuprofen	_____
☐ Codeine	_____
☐ Other (specify)	_____

PLEASE READ AND SIGN: The information on my intake form(s) is correct to the best of my knowledge. I understand that throughout my treatment, I am responsible for notifying the physician and/or medical staff of any and all updates to the information listed above. *(Assignment of Benefits):* I authorize payment of medical benefits to the practice named above. *(Release of Information):* I authorize the release of any medical information necessary to process this claim. *(HIPAA Privacy):* I acknowledge that I received my HIPAA Privacy Practices Notice. *(Medication History):* I authorize the Doctor''s office to retrieve my medication history.

Patient Signature: _____ Date: _____

Rev 10/7/2011

No-Show Policy

Welcome to Imperial Foot & Ankle Specialists, Inc. In order to provide the most efficient scheduling to our patients, we need to keep appointment cancellation and “no-show” activity to a minimum. In order to do this, we are implementing cancellation and “no-show” fees that will be charged to the patient if the office visits and/or procedures are cancelled without proper advance notice, or if the patient does not show up for the scheduled office visit and/or procedure.

Scheduled appointments are reserved especially for you. Due to the high number of patients requesting appointments, waiting time can be long. Because of this, the office has a low tolerance for missed appointments that waste resources and prevent other patients from receiving care in a timely manner.

When you do not show for a scheduled appointment, it creates an unused appointment slot that could have been used for another patient. It is important that you call within 24 hours in advance to cancel your appointment.

As a courtesy, we make every effort to remind patients of their appointments by telephone 2-3 business days before the office visit date. These are not calls to confirm the appointment, but are calls to remind the patient of their appointment. It is your responsibility to provide us with the appropriate advance notice if you need to cancel an office visit.

If an appointment is missed, cancelled or rescheduled with less than 24 hour advanced notice, then you will be billed at least a $50.00 No-Show Fee. The No-Show fee may be more than $50.00 and will be based according to the schedule fee and instructions of your benefit plan.

The cancellation and “No-Show” fees are the sole responsibility of the patient and must be paid in full before the patient’s next appointment.

After three consecutive “No-Show” occurrences, the practice may elect to terminate our relationship with you.

Our practice firmly believes that good physician/patient relationship is based upon understanding and good communication. We understand that special unavoidable circumstances may cause you to cancel within 24 hours. Fees in this instance may be waived but only with management approval.

Please sign that you have read, understand and agree to this No-Show Policy.

_____ _____

Patient Name (Please Print) **Date of Birth**

_____ _____

Signature of Patient or Patient Representative **Date**

Patient Financial Policy

Imperial Foot & Ankle Specialists, Inc. is committed to providing you with the best possible care. If you have medical insurance, we are committed to help you receive the maximum allowable benefits. Take into consideration, it's a courtesy to bill your secondary insurance, it's not required by law. Therefore, In order to achieve these goals, we need your assistance in understanding our financial policy.

Without exception, it is the responsibility of the patient to pay his/her co-payment and any unpaid portion of the deductible at the time of service. Any additional co-payments, deductibles, and/or co-insurance will be billed to the patient. All patients without insurance must pay in full at the time services are rendered. If you have any deductible, you will need to leave a credit card on file or open a Care Credit account. If you do not have a credit card or Care credit account at the time of visit and your deductible has not been met, you will be required to pay the office visit/procedure in full at the time of service.

In the case of an overpayment, all refunds will be processed within 6-8 weeks after the overpayment is discovered on the patient's account or at the time the refund is requested. Patient's who have insurance but made a partial payment or made payment in full will not be refunded until payment in full is received from their insurance company.

Whenever your share of the total cost charges are $99.00 or less and 60 days or older, they can be automatically charged to your account or Care Credit. If your charges are $100.00 or more, that balance will be automatically charged to your account or Care Credit without a numbered day delay.

Return checks will be accessed a $25.00 return check fee and may be subject to additional collection fees and interest charges of 1.5% per month.

Any time during your treatment, should you become ineligible for insurance coverage, you need to notify this office immediately. All charges after insurance coverage is terminated will be your responsibility.

We will gladly discuss your proposed treatment and answer any questions relating to your insurance.

Signature: _____ **Date:** _____

_____

Please circle: Visa MasterCard Discover American Express Care Credit

Credit Card Number: _____ **Exp Date:** _____

I authorize Imperial Foot & Ankle Specialists, Inc. to use the credit card mentioned above to pay any unpaid patient responsibility fees older than 60-days with the credit card listed above.

Name of Credit Card Holder: _____ **Date:** _____

Signature: _____

Patient Financial Policy

Signature: _____