Advanced Carolina Foot and Ankle Center
516 Village Court • Garner, NC 27529 • 919.661.4150

Date _____ Account #_____

Demographic Information

Last_____First_____MI_____ Sex M F

Patient SS #_____ Date of Birth_____

Marital Status S M D W **Name of Spouse _____**

Home Address_____

City_____ State_____ Zip_____

Home_____Work_____Cell_____

E-Mail _____

Pharmacy Name and telephone # _____

Employer Name _____ Job Title _____

Address_____

Company Phone_____

How did you hear about us? (circle one)

Internet/Google Friend/Family Doctor Referral (who?) _____

Insurance Company Facebook Other _____

Name and relationship of Emergency Contact _____

Phone number of Emergency Contact _____

Name of Family Physician_____ **Date last seen:** _____

Phone_____ **Fax**_____

Address_____

I have received and reviewed the Notice of Privacy Practices

_____ _____

SIGNATURE OF RESPONSIBLE PARTY DATE

Person responsible for services rendered if different than listed above

Name_____ SS#_____

Address_____

Phone_____ **DOB** _____

Medical History

Please describe what brings you to the office today

_____

_____

Past medical history:

hypertension/high blood pressure HIV/AIDS hepatitis heart attack/MI

insulin dependent diabetes non insulin dependent diabetes stroke/CVA aneurysm

blood clot

Past medical history – injuries/trauma/medical problems

_____

_____

Have you had any of the following foot surgeries?

toenail bunion hammertoe fracture repair joint fusions
tendon repair/rerouting ankle stabilization arthroscopy fasciotomy

Please list approximate month and year of any surgery listed above:

_____

Have you had any of the following surgeries?

heart bypass heart valve repair/replacement appendectomy
gallbladder brain surgery
other_____

Please list approximate month and year of any surgery listed above:

_____

Any other surgeries? (Please specify type of surgery and date)

_____

Social History

Do you?

smoke tobacco smoke marijuana use hallucinogenic drugs
drink alcohol use cocaine use other recreational drugs

Alcohol (number of drinks)

Number of drinks a day _____ greater than 5 per day ____ 1-3 drinks per week
4-6 drinks per week occasional use social drinking only weekend drinking only

Tobacco (number of packs)

____ pack per day 5 or more packs per day 1-2 packs per week 3-4 packs per week

Occasional smoking only social smoking only weekend smoking only

If you use other recreational drugs - please list/specify:

_____

Medications - please list medications (including aspirin) currently taking:

_____

_____

_____

Allergies - Do you have allergies to any of the following:

drug allergies penicillin sulfa erythromycin

aspirin cortisone codeine adhesive tape

local anesthetics **no known allergies**

Other allergies to medications - please list:

_____

Vitals

Height_____ Weight_____

Blood Pressure _____/_____

Blood Sugar (if Diabetic) _____

Shoe Size_____

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Welcome To Our Practice

We would like to thank you for allowing us to treat you as a patient. We are pleased to meet any podiatric needs you or your family have. We will **always** do our best to provide you with the most compassionate and professional care available. To avoid any confusion, we have listed some of our office policies and procedures.

- As a courtesy, Advanced Carolina Foot and Ankle Center, PLLC will file your medical claim with your insurance company. Your deductible and co-pay or any portion not covered by your insurance company is due at the time of service. Please remember that your insurance is a contract between you, your employer, and your insurance company. We will gladly act as an advocate, but cannot be responsible for settling disputes with insurance. For patients without insurance coverage, **you will be responsible for your payment in full on the day of treatment**.

- **Broken appointments are very costly and inconvenient**. Please inform us no less than 24 hours in advance if you are unable to keep your appointment. For appointments broken or cancelled less than 24 hours in advance, we will charge a $25 fee. For our Medicaid patients, we can no longer continue your podiatric care in this office if you have had 3 missed appointments.

- If you are more than 15 minutes late for your scheduled appointment, you may be rescheduled to another day. ***This will be considered a broken appointment.***

- All patients under the age of eighteen (18) years old will not be seen or treated, in the absence of a parent or legal guardian, without a signed consent form.

- You are responsible to pay the cost of collecting any debt owed on your account. This includes all attorney's fees, late fees, and interest to be charged.

By signing below, you have read and understood our Notice of Privacy Practices. A copy of this agreement is available upon request.

Your cooperation is greatly appreciated in this matter. If you have any questions, please feel free to ask our friendly staff.

Signature:_____ Date:_____