Haag Foot & Ankle Center, PLLC

Dr. Cheryl A. Haag
Dr. Lester T. Haag
Specializing in Diseases & Surgery of the Foot & Ankle
Phone: 423-396-3668 Fax: 423-396-2436

Patient Information

Name:_____**Date of Birth:**_____**Age:**_____

S.S.#:_____-_____-_____ **Sex: [ ] MALE [ ] FEMALE**

Marital Status : [ ] Single [ ] Married [ ] Divorced [ ] Widowed

Address:_____**City**_____**State**_____**Zip Code**_____

Phone: Home ( )_____**Work ( )**_____**Cell ( )**_____

Email Address:_____

Occupation:_____ **Employer:**_____

Primary Care Physician:_____**Phone: ( )**_____

Date of last visit:_____

How were you referred to our office?_____

<u>Emergency Contact Information:</u>

Name:_____**Relationship:**_____

Phone: Home ( )_____**Work ( )**_____**Cell ( )**_____

<u>Responsible Party/Primary Insurance Carrier (</u>If not Self):

Name:_____**Date of Birth:**_____**Relationship:**_____

S.S.#:_____-_____-_____ **Sex: MALE FEMALE**

Phone: Home ( )_____**Work ( )**_____**Cell ( )**_____

Resp. Party Employer:_____**Employer Phone: ( )**_____

I certify that the information given above is true and correct. I understand that it is my responsibility to notify *Haag Foot & Ankle Center* of any changes to the above information.

Patient / Guardian Signature_____**Date:**_____

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Please answer for HIPAA compliance

May we leave lab, testing results, appointment reminders, and surgical procedure dates on your home answering machine or voicemail?

YES NO Patient Signature:_____Date:_____

With whom do you allow us to share your health information if you are unavailable?

Name:_____Relationship:_____

Name:_____Relationship:_____

Name:_____Relationship:_____

Race: (check one)

___White
___African American
____Asian
___Hawaiian or other Pacific Islander
___American Indian
___Other_____

Ethnicity: (check one)

___Hispanic or Latino
___Not Hispanic or Latino

What is your **primary language**? Cual es su idioma? 'Quelle est votre langue?

_____

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1. **Allergies:**

__Penicillin	__Radiographic Contrast/Dyes	__Shellfish
__Narcotic Agents/Codeine	__Aspirin	__Other_____
__Sulfa Drugs	__Anesthesia	__None Known**

2. **Please List all Medications/Herbs/Vitamins and their strengths:**

_____
_____
_____
_____

3. **What is your Pharmacy Name?_____Phone #_____**

4. **Past Medical History:**

__ Anemia	__High Cholesterol	__Osteoarthritis	__Bleeding Disorder
__ HIV/Aids	__Prostate Disorders	__Cancer	__High Blood Pressure
__Rheumatic Disorders	__Diabetes	__Kidney Disease	__Thyroid Disorder
__Epilepsy	__Lung Disorder	__Stroke	__Gout
__Mitral Valve Prolapse	__Heart Disease	__Nerve Disorders	__Hepatitis
__Neurologic	__Other:_____		

5. **Past Surgical History:**
Have you had surgery? YES NO
Describe (surgery/date):_____
_____

6. **Social History:**

__Tobacco Use	__Drug Use	__Caffeine Use	__Exercise Habits
__Alcohol Use	__Pregnant	__Nursing	

7. **Do you smoke? YES NO If yes, how often_____**

8. **Constitutional Symptoms:**

__Chills	___Fever	__Sweats	__Weight Loss

9. **Cardiovascular:**

__Cardiovascular Surgery	__Heart Attack	__Palpitations
__Chest Pain	__Heart Murmur	__Swelling in Legs/Ankles
__Congestive Heart Failure	__Leg Pain w/Exercise	

10. **Endocrine:**

__Diabetes Mellitus	__Often Urinating	__Prostate Problems
__Kidney Disease	__Often Thirsty	__Thyroid Disorder

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11. Head, Eyes, Ears, Nose, and Throat:

__Contacts __Dentures __Neck Pain
__Cataracts __Dizziness __Ringing in Ears
__Double Vision __Difficulty Swallowing __Sore Throat
__Eyeglasses __Nose Bleeds

12. Gastrointestinal:

__Acid Reflux __Decrease in Appetite __Nausea
__Blood in Stool __Diarrhea __Stomach Ulcers
__Constipation __Hepatitis __Vomiting

13. Integumentary:

__Change in Skin Color __Hair Loss __Recurrent Infections
__Cracking of the Skin __Keloid __ Sensitivity to Sun
__Eczema __Lesions __Skin Ulcers
__Growth on Skin __Rash

14. Hematologic/Lymphatic:

__Anemia __Lymphoma __ Swollen Glands
__Bleeding Abnormalities __Lump in Groin or Armpit

15. Musculoskeletal:

__Arthralgia __Feeling Weak __Weakness of Limbs
__Broken Bone __Joint Pain
__Bursitis __Tendonitis

16. Nervous System:

__Aphasia (loss of speech) __Migraines __Speech Difficulties
__Ataxia (loss of balance) __Nervous Disorders __Stroke
__ Confusion __Neuropathy (loss of sensation)
__ Fainting __Seizures

17. Psychiatric:

__Depression __Nervousness __Tension

18. Respiratory:

__Asthma __Difficultly Breathing __Pulmonary Disease
__Bronchitis __Emphysema __Tuberculosis Exposure or
__Cough __Pneumonia Treatment

19. Family History (*Indicate M for Mother or F for Father*)

__Diabetes __Bleeding Disorders __High Blood Pressure
__Kidney Disease __Rheumatology __Mental Illness
__Heart Disease __Cancer __Stroke
__Other Family History_____

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20. Explain your foot/ankle problem:_____

21. When did pain/discomfort begin? (date)_____

Describe pain/discomfort: Burning Numbness Sharp Other:_____

22. What makes pain/discomfort better? _____

23. What makes pain/discomfort worse? _____

24. Has condition been treated? YES NO When and how:_____

25. What is your shoe size?_____ Male Female Child (circle appropriate answers)

To the best of my knowledge, the questions on these forms have been accurately answered.
I understand that providing incorrect information can be dangerous to my health.

Patient or Guardian Signature:_____Date:_____

ACKNOWLEDGEMENT OF RECEIPT
OF
NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided the opportunity to see 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.

_____ _____
Signature of Patient (or Guardian) **Date**

_____
Patient Name (Please Print)

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HAAG FOOT & ANKLE CENTER ASSIGNMENT OF BENEFITS AND FINANCIAL AGREEMENT

My signature at the bottom of this form authorizes payment for services rendered to myself or my dependent to be made directly to *Haag Foot & Ankle Center.* This authorization is valid until I notify *Haag Foot & Ankle Center* in writing that it is revoked.

I understand that I am responsible for giving "*Haag Foot & Ankle Center"* the correct insurance information at the time services are rendered. *Haag Foot & Ankle Center* agrees to bill your primary insurance carrier. If payment is not received from your secondary within 45 days the balance becomes your responsibility. All insurance information must be provided to our office at the time of service.

I understand that I am responsible for obtaining the proper referral and may be held responsible for charges not covered by my insurance due to my failure to obtain the required information.

I agree to pay for non-covered services under my insurance plan (services for which I have a policy exclusion) I understand that all co-pays are to be paid before services are rendered.

I understand that *Haag Foot & Ankle Center* is not responsible for knowing if the group/physician is a participating provider with my insurance carrier, or is considered "in network".

We at *Haag Foot & Ankle Center* expect that all accounts should be paid by the receipt of the first two statements. If your account has not been settled either by payment in full or by contacting our billing department to set up a payment plan we will be charging a $10 re-billing fee, for each statement that we mail. If you have made arrangements with our office we will not charge you the re-billing fee for statements sent. Your account will be turned over to collections if you do not fulfill the terms of your financial arrangements.

I understand that there is a $25 fee for all returned checks.

I understand that if I do not call to cancel my appointment within 24 hours there will be a $25 fee applied to my account.

I agree to show up to all my scheduled appointments on time and understand that if I come late the appointment may need to be rescheduled in order to be fair to all patients.

I understand that I am responsible for all balances not paid by my insurance carrier, including deductibles, co-pays, and co-insurance and out of network penalities. I further understand that if this balance is turned over to an outside collection agency that I shall be liable for all costs of collection and attorney fees and or court costs incurred by this office.

_____ _____

Signature of Patient/Guardian, or Legal Representative **Date**