Edmond Podiatry, LLC dba **Central Oklahoma Foot and Ankle Center**

PATIENT INFORMATION (Please Print)

☐ Dr. ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Jr. ☐ Sr. ☐ Other: _____

Patient's Name (Last) _____ (First) _____ (Middle) _____

Also Known As Name (Last) _____ (First) _____

Marital Status ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Legally Separated ☐ Other

Social Security Number ___-___-___ ☐ Female ☐ Male Date of Birth ___/___/___

Phone Numbers: Home _____ Work _____

Cellular _____ *May we leave a message on your phone?* ☐ *Yes* ☐ *No*

E-Mail _____

Address _____

City, State, ZIP _____

Employment Status ☐ Employed Full Time ☐ Employed Part Time ☐ Full Time Student ☐ Part Time Student ☐ Retired ☐ Self Employed ☐ Unemployed

Employer _____ Occupation _____

Emergency Contact Name _____ Contact Number _____ Relationship _____

Primary Care Physician _____ Referring Provider _____

RESPONSIBLE PARTY INFORMATION

☐ **SELF** *or* Name: (Last) _____ (First) _____ (Middle) _____

Also Known As Name (Last) _____ (First) _____

Social Security Number ___-___-___ ☐ Female ☐ Male Date of Birth ___/___/___

Phone Numbers: Home _____ Cellular _____ Work _____

Address _____

City, State, ZIP _____

Employment Status ☐ Employed Full Time ☐ Employed Part Time ☐ Full Time Student ☐ Part Time Student ☐ Retired ☐ Self Employed ☐ Unemployed

Employer _____ Occupation _____

Patient Relationship to Responsible Party _____

PRIMARY INSURANCE INFORMATION (provide your insurance card to the front desk at check-in)

Name of Policyholder: _____ Patient Relationship to Policyholder _____

Policyholder Employer Name _____

Insurance Company/Phone Number _____ (___) _____

Member ID _____ Group ID _____ Copay Amount _____

Effective Date _____ Termination Date _____ ☐ Female ☐ Male

Policyholder Date of Birth ___/___/___ Policyholder Social Security Number ___-___-___

Insurance Company Address _____

SECONDARY INSURANCE INFORMATION (provide your insurance card to the front desk at check-in)

Name of Policyholder: _____ Patient Relationship to Policyholder _____

Policyholder Employer Name _____

Insurance Company/Phone Number _____ (___) _____

Member ID _____ Group ID _____ Copay Amount _____

Effective Date _____ Termination Date _____ ☐ Female ☐ Male

Policyholder Date of Birth ___/___/___ Policyholder Social Security Number ___-___-___

Insurance Company Address _____

I agree that the information supplied on this form is accurate and up-to-date to the best of my knowledge.

Patient (or Responsible Party) Signature _____ ***Date*** _____

Medical Center *Edmond*

CENTRAL OKLAHOMA FOOT & ANKLE CENTER

FINANCIAL POLICY

As your physician, I am committed to providing you the best medical care and to that end, I am committed to discussing your proposed treatment and the cost of those services to keep you informed of your financial responsibility. Your input in your treatment is essential to that end and, as a reminder; your insurance is a contract between you, your employer and/or your insurance company. If you are aware of non-covered benefits, it is your responsibility to inform staff prior to services being rendered. It is also necessary that each visit's copayment or any outstanding deductibles are paid at the time services are rendered.

For your convenience, insurance is filed by this office in most situations. The patient is responsible for providing the correct insurance information to the staff. All services provided are to be paid at the time of service unless other payment arrangements are made with the staff. Any **CHANGES** to your information must also be provided when related to claims filed for you or filed for a dependent covered by you. The changes could include the following: address, phone, employment, insurance payer, responsible party, and policy and group numbers. _____ **(Patient Initials)**

MEDICARE: I am participating with Medicare and will file claims on your behalf. For any non-covered service (routine/preventative) an Advanced Beneficiary Notice (ABN form) will be provided to you outlining the non-covered service and the reason service is not covered and the estimated cost to you. Otherwise, you are responsible for 20% of allowable charges and any deductibles not covered by secondary or supplemental insurance.

HMO INSURANCE: Referrals must be obtained prior to services being rendered by members of Managed Care programs. The patient is responsible for notifying or obtaining a referral from their Primary Care Physician (PCP) before the appointment. Failure to provide the necessary referral information will result in cancellation of your appointment.

AUTO or THIRD-PARTY INSURANCE: Injuries sustained by auto accidents or accidents covered by a third-party are the responsibility of the patient to file and payment for these services are expected at the time service is rendered.

WORKERS COMPENSATON CLAIMS: Patients with workers compensation claims are the responsibility of the patient to file and payment for these services are expected at the time service is rendered.

SELF-PAY CLAIMS: Patients without insurance coverage are expected to provide notification to the staff and will be asked to provide payment in full at time services are rendered or make payment arrangements with the staff, if needed. A $100 non-refundable deposit is required to secure an appointment and will be applied to the time of service.

Any balances remaining on an account after 90 days will be pursued for payment by the accounting department or by collection services. On occasion, emergencies are beyond any one's control that affect financial obligations; if this happens, please contact this office or the Customer Support line promptly for assistance.

BY MY SIGNATURE BELOW, I AGREE TO THE FINANCIAL POLICY AS OUTLINED ABOVE.

_____ _____

SIGNATURE (Responsible Party or Patient) DATE

_____ _____

WITNESS DATE

Medical Center *Edmond*

CENTRAL OKLAHOMA FOOT & ANKLE CENTER

Patient HIPAA Acknowledgment and Consent Form

Patient Name: _____

Date of Birth: _____

_____ **(Patient initials) Notice of Privacy Practices.** I acknowledge that I have received the practice's Notice of Privacy Practices, which describes the ways in which the practice may use and disclose my healthcare information for its treatment, payment, healthcare operations and other described and permitted uses and disclosures, I understand that I may contact the Privacy Officer designated on the notice if I have a question or complaint. To the extent permitted by law, I consent to the use and disclosure of my information for the purposes described in the practice's Notice of Privacy Practices.

_____ **(Patient initials) Release of Information.** I hereby permit practice and the physicians or other health professionals involved in the inpatient or outpatient care to release healthcare information for purposes of treatment, payment, or healthcare operations.

- Healthcare information regarding a prior admission(s) at other HCA affiliated facilities may be made available to subsequent HCA-affiliated admitting facilities to coordinate Patient care or for case management purposes. Healthcare information may be released to any person or entity liable for payment on the Patient's behalf in order to verify coverage or payment questions, or for any other purpose related to benefit payment. Healthcare information may also be released to my employer's designee when the services delivered are related to a claim under worker's compensation.
- If I am covered by Medicare or Medicaid, I authorize the release of healthcare information to the Social Security Administration or its intermediaries or carriers for payment of a Medicare claim or to the appropriate state agency for payment of a Medicaid claim. This information may include, without limitation, history and physical, emergency records, laboratory reports, operative reports, physician progress notes, nurse's notes, consultations, psychological and/or psychiatric reports, drug and alcohol treatment and discharge summary.
- Federal and state laws may permit this facility to participate in organizations with other healthcare providers, insurers, and/or other health care industry participants and their subcontractors in order for these individuals and entities to share my health information with one another to accomplish goals that may include but not be limited to: improving the accuracy and increasing the availability of my health records, decreasing the time needed to access my information, aggregating and comparing my information for quality improvement purposes, and such other purposes as may be permitted by law. I understand that this facility may be a member of one or more such organizations. This consent specifically includes information concerning psychological conditions, psychiatric conditions, intellectual disability conditions, genetic information, chemical dependency conditions and/or infectious diseases including, but not limited to, blood borne diseases, such as HIV and AIDS

Disclosures to Friends and/or Family Members

I give permission for my Protected Health Information to be disclosed for purposes of communicating results, findings and care decisions to the family members and others listed below:

	Name	Relationship	Contact Number
1			
2			
3			

Consent to Email or Text Usage for Appointment Reminders and Other Healthcare Communications:
Patients in our practice may be contacted via email and/or text messaging to remind you of an appointment, to obtain feedback on your experience with our healthcare team, and to provide general health reminders/information.
If at any time I provide an email or text address at which I may be contacted, I consent to receiving appointment reminders and other healthcare communications/information at that email or text address from the Practice.

_____ **(Patient initials)** I consent to receive text messages from the practice at my cell phone and any number forwarded or transferred to that number or emails to receive communication as stated above. I understand that this request to receive emails and text messages will apply to all future appointment reminders/feedback/health information unless I request a change in writing (see revocation section below).
The cell phone number that I authorize to receive text messages for appointment reminders, feedback, and general health reminders/information is_____
The email that I authorize to receive email messages for appointment reminders and general health reminders/feedback/information is_____

The practice does not charge for this service, but standard text messaging rates may apply as provided in your wireless plan (contact your carrier for pricing plans and details).

Revocation
I hereby revoke my request for future communications via email and/or text.
__I hereby revoke my request to receive any future appointment reminders, feedback, and general health via text messages.
__ I hereby revoke my request to receive any future appointment reminders, feedback, and general health via email.
NOTE: This revocation only applies to communications from this Practice.
Patient Name: _____

Patient/Patient Representative Signature: _____

Date: _____ *Time:* _____

Consent for Photographing or Other Recording for Security and/or Health Care Operations
____ **(Patient Initials)** I consent to photographs, videotapes, digital or audio recordings, and/or images of me being recorded for security purposes and/or the practice's health care operations purposes (e.g., quality improvement activities). I understand that the facility retains the ownership rights to the images and/or recordings. I will be allowed to request access to or copies of the images and/or recordings when technologically feasible unless otherwise prohibited by law. I understand that these images and/or recordings will be securely stored and protected. Images and/or recordings in which I am identified will not be released and/or used without a specific written authorization from me or my legal representative unless it is for treatment, payment or health care operations purposes or otherwise permitted or required by law.

Prescription Order Pick-up. There may be times when you need a friend or family member to pick-up a prescription order (script) from your physician's office. In order for us to release a prescription to your family member or friend, we will need to have a record of their name. Prior to release of the script, your designee will need to present valid picture identification and sign for the prescription.
____ **(Patient initials)** I wish to designate the following family member / friend to pick up an order on my behalf:
Name _____ Date: _____
Name: _____ Date: _____
____ **(Patient initials)** I **do not** want to designate anyone to pick-up my prescription order.

Patient Signature _____ **Date** _____

ALLERGIES (include reaction and date):

____

____

____

____

____

____

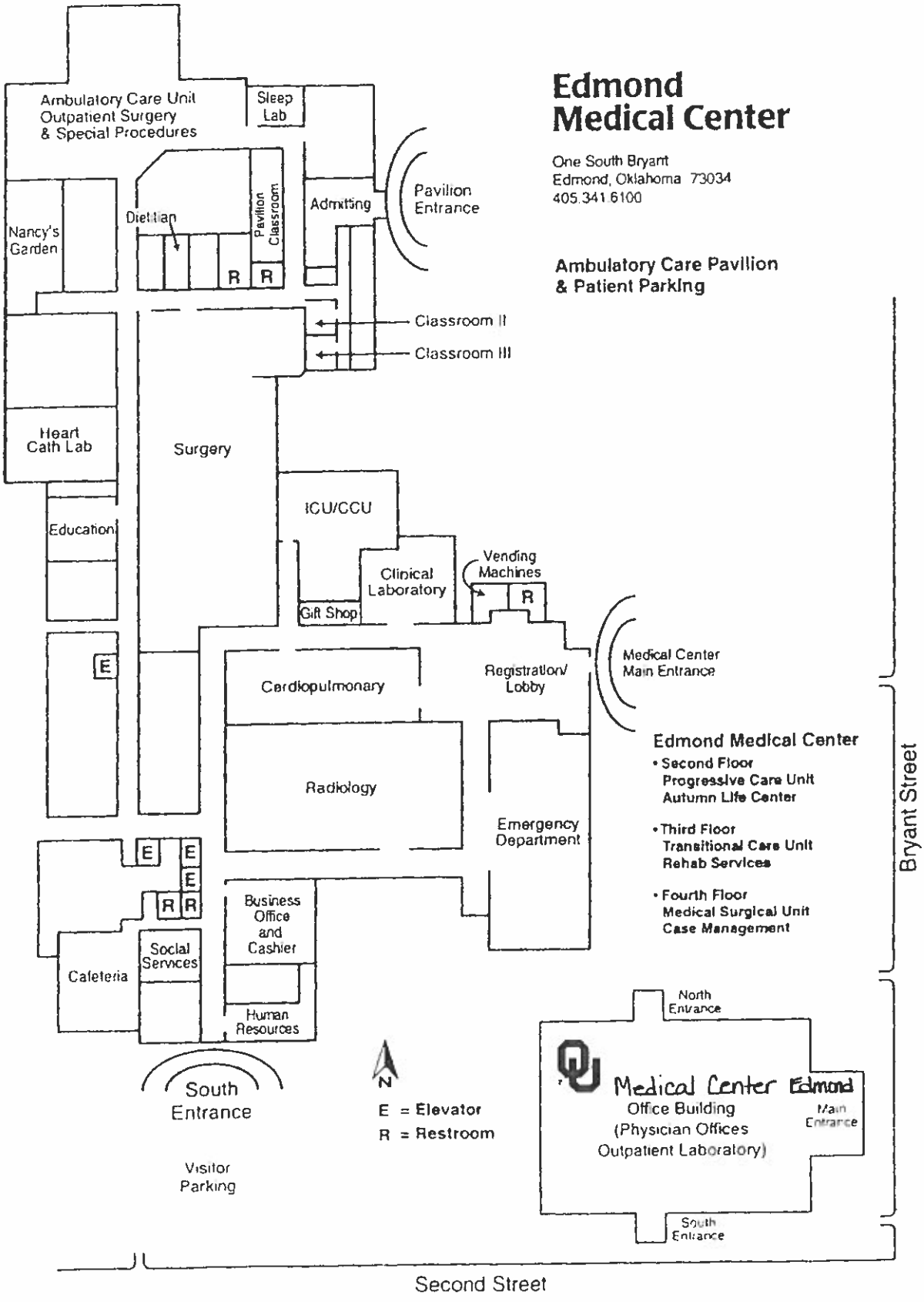
NAME: ______________________________

DOB: ______________________________

MEDICATION LIST

Date Reviewed
(Include your initials)

Medication Name (brand & generic)	Dosage (strength & Frequency)																						


Edmond
Medical Center
One South Bryant
Edmond, Oklahoma 73034
405.341.6100
Ambulatory Care Pavilion
& Patient Parking
Ambulatory Care Unit
Outpatient Surgery
& Special Procedures
Sleep Lab
Pavilion Classroom
Admitting
Pavilion Entrance
Nancy's Garden
Dietitian
R
R
Classroom II
Classroom III
Heart Cath Lab
Surgery
ICU/CCU
Education
Clinical Laboratory
Vending Machines
R
Gift Shop
E
Cardiopulmonary
Registration/ Lobby
Medical Center Main Entrance
Radiology
Emergency Department
Edmond Medical Center
• Second Floor
Progressive Care Unit
Autumn Life Center
• Third Floor
Transitional Care Unit
Rehab Services
• Fourth Floor
Medical Surgical Unit
Case Management
E
E
E
R
R
Business Office and Cashier
Social Services
Cafeteria
Human Resources
North Entrance
Medical Center Edmond
Office Building
(Physician Offices
Outpatient Laboratory)
Main Entrance
South Entrance
South Entrance
N
E = Elevator
R = Restroom
Visitor Parking
Bryant Street
Second Street

PATIENT HISTORY

***Please fill out all forms to the best of your ability. The staff will go over the form and answer any questions you have.**

Patient Name _____ Date ____/____/____

Age _____ Height _____ Weight_____ Shoe Size_____

Primary Care Physician and Phone _____ Date Last Seen ____/____/____

1) What is the main problem with your feet or ankles? _____

_____

2) When did you notice the condition? _____

3) Is this an injury? ____ Yes ____ No If Yes, when did it occur? ____/_____/_____

If Yes, did it happen at work? _____Yes _____No Are you claiming Workman's Comp? _____Yes _____No

4) Check all of the following that apply?

Type of Pain ☐ Burning ☐ Tingling ☐ Sharp ☐ Dull Ache ☐ Throbbing

☐ Shooting ☐ Stabbing ☐ Numbness

When Painful ☐ Upon Standing ☐ During Walking ☐ After Walking

☐ During Sports ☐ Worse with Activity ☐ Better as Activity Continues

☐ Worse when standing ☐ With Shoes ☐ Without Shoes

☐ A.M. ☐ P.M. ☐ Lying in Bed ☐ Always

5) How painful is your condition? If **0**="no pain" and **10**="the worst pain you have ever experienced", please circle your pain level: **0 1 2 3 4 5 6 7 8 9 10**

6) How has this affected your daily routine and what activities does this keep you from performing? _____

_____

7) Have you had foot care before? ____ Yes ____ No By whom and when: _____

_____

MEDICATIONS

Pharmacy _____ Phone Number _____

Medication	Dosage	How Often Taken?	What is it Taken for?

ALLERGIES

☐ NONE ☐ Latex ☐ Metal ☐ Nickel ☐ Novacaine ☐ Anticoagulant Therapy

☐ Penicillin ☐ Sulfa ☐ Iodine ☐ Aspirin ☐ Anesthetics ☐ Adhesive/Tape

☐ Codeine ☐ Demerol ☐ Darvocet ☐ Cortisone ☐ Environmental ☐ Food

Other _____

Type of Reactions _____

MEDICAL HISTORY

*Please check any of the following conditions that you have or have had in the past.

☐ Diabetes ☐ Fibromyalgia ☐ Tumors ☐ Epilepsy ☐ Nerve Conditions ☐ Heart Problems

☐ Arthritis ☐ Asthma/COPD ☐ Gout ☐ Glaucoma ☐ Stomach Ulcers ☐ Skin Disorders

☐ Tuberculosis ☐ Anemia ☐ Bursitis ☐ AIDS(HIV) ☐ Lung Disease ☐ Kidney Problems

☐ Sickle Cell ☐ Stroke ☐ Hepatitis ☐ Osteoporosis ☐ Bleeding Problems ☐ Colitis/Crohn's

☐ Mental Disorders ☐ Poor Circulation ☐ High Blood Pressure ☐ Joint Implants ☐ Thyroid Disease

☐ Rheumatic Fever ☐ Heart Burn/Reflux ☐ Sexually Transmitted Diseases ☐ High Cholesterol

☐ Cancer; Type _____ Other _____

☐ Diabetes: What is the name, phone number, and address of the doctor treating you for diabetes? _____

_____

When was your last visit? ____/____/____ What is your average blood sugar reading? _____

Are you pregnant? _____ Yes _____No How many months? _____

SURGICAL HISTORY

Procedure	Date	Complications

Have you ever been hospitalized other than for surgery? ____ Yes _____No Explain_____

_____

Have you ever had an injury to the lower extremity? ____ Yes ____No Explain _____

_____

FAMILY HISTORY

*Please check all that apply

	FATHER	MOTHER	BROTHER	SISTER
Diabetes				
Heart Disease				
High Blood Pressure				
Arthritis				
Gout				
Thyroid				
Cancer (what type)				
Other				

SOCIAL HISTORY

Date of last physical exam ____/____/____ Occupation _____

Activities _____

Level of activity: _____ Occasional _____ Weekly _____ Competitive _____ Professional

Do you smoke tobacco? _____ Yes _____ No

If Yes: # packs per day? _____ # cigarettes per day? _____ # of years smoking? _____

If No: Did you ever smoke? _____ Yes _____ No

If Yes: How long ago did you stop smoking? _____

Do you drink alcohol? _____ Yes _____ No

If Yes: How much? _____ <1 per week _____1-2 per week _____ 1-2 per day _____ more than 3 per day

Recreational drug use

Any type of drug use is a personal choice and will in no way adversely effect your relationship with the doctor. However, many drugs can interact with other medications and treatments with potential life threatening effects. Therefore, it is extremely important that you answer honestly. Your response will be held in the most strict patient-doctor confidentiality.

Answer _____ Yes _____ No

If Yes: What substance and how often used _____

REVIEW OF SYSTEMS

*If you experience any of the following please circle

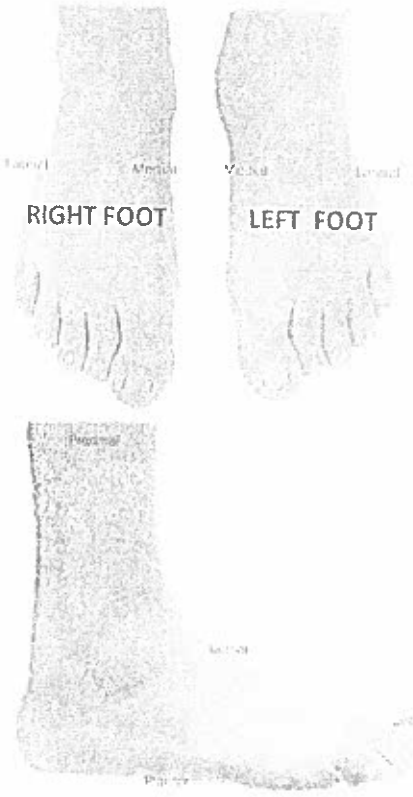
Head: chronic headaches, concussions, dizziness, loss of consciousness. **Eyes:** glasses, contacts, double vision, blurred vision, blindness, cataracts. **Ears:** decreased or loss of hearing, ringing in the ears, chronic earaches. **Nose:** drainage or infection, bleeding, sinusitis. **Throat:** chronic tonsillitis, laryngitis, difficulty swallowing, loss of speech. **Cardiovascular:** chest pain, shortness of breath, palpitations, murmurs, heart valve disease, anemia, leg cramps. **Respiratory:** bronchitis, pneumonia, difficulty breathing, wheezing, chronic cough. **Gastrointestinal:** nausea, vomiting, diarrhea, constipation, weight gain or loss, blood in stool, black stool, loss of appetite. **Genitourinary:** chronic kidney or bladder infections, problems voiding, pain with urination, dark or bloody urine. **Other:** _____

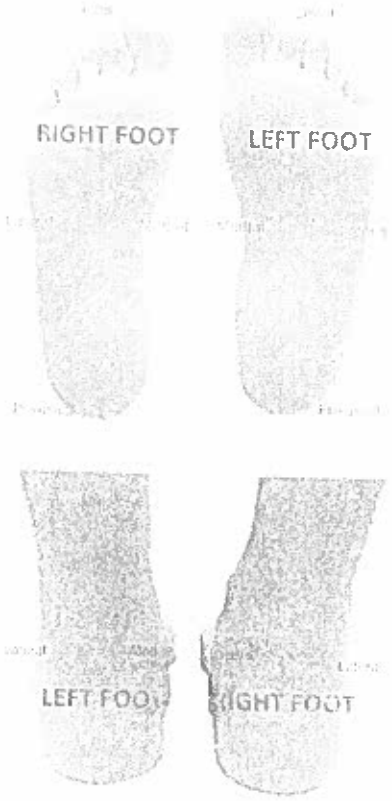
Do your legs swell? _____ Yes _____ No

Do you have back problems or have had a back injury? _____ Yes _____ No

☐ **I am not experiencing any of the above symptoms.**

Please circle where on your feet/ankles you are having pain.





Patient Name:_____ **Date:**_____

*** Do not complete. The following is for office and physician use only.**

General:(well developed, well nourished, age, sex, weight, height, shoe size, alert, oriented, distress)

Vascular:(pedal pulses, temp, color, CFT, varices, edema, trophic changes, turgor, hair growth and distribution, cyanoses, pallor, rubor, telanglectasis, phlebitis, intermittent claudication, rest pain, other)

Neurologic:(DTR, sensation, proprioception, vibratory, sharp/dull, babinski, clonus, tinel, valleix, other)

Dermatologic:(temp, texture, turgor, hair growth and distribution, atrophy, lesions, lacerations, macerations, scaling, xerosis, masses, nails, other)

Musculoskeletal: (strength, tone, symmetry, atrophy, limb length discrepancy, genu varum/valgum, tibial torsion, psedolack of mallelolar torsion, ROM hip/knee, scoliosis, other)

	Right	Left	
Ankle	DF_____	DF_____	Pain, Crepitus, Effusion, Equinus_____
	PF_____	PF_____	_____
STJ	INV_____	INV_____	Pain, Crepitus, ROM, Effusion_____
	EV_____	EV_____	_____
	Neut_____	Neut_____	Right: Everted / Inverted Left: Everted / Inverted
RCSP	_____	_____	Right: Everted / Inverted Left: Everted / Inverted
Midtarsal	_____	_____	Pain, Crepitus, Effusion_____
1st Ray	Hypermobile	Hypermobile	Pain, Crepitus, Position_____
HA Angle	_____	_____	Tracking or Trackbound_____
1st MPJ	DF_____	DF_____	Pain, Crepitus, Structural, Positional, Effusion,
	PF_____	PF_____	Sesamoidal Tenderness_____
Lesser MPJ,Digits	_____	_____	Pain, Crepitus, Effusion_____
Contractures	1 2 3 4 5	1 2 3 4 5	Flexible or Rigid

Posture, Gait, Other Deformities: Right Left

Radiographs: Diagnosis/Plan