Wilmington Foot & Ankle, Inc.

Name_____ Birthdate_____SS#_____-_____-_____

Sex: M F Daytime Phone_____ Evening Phone _____ Marital Status_____

Race_____ Ethnic Group_____ Language_____

Address _____City _____ Zip _____

Family Physician _____Address and Phone # _____

Pharmacy _____Address and Phone # _____

Emergency Contact:_____

1st Insurance:
Co._____

2nd Insurance:
Co._____

Subscriber _____Subscriber _____

Subscriber's Date of Birth:_____ Subscriber's Date of Birth_____

Past Medical History: E-mail _____

Anemia	Yes	No	Glaucoma	Yes	No	Pneumonia	Yes	No
Arthritis	Yes	No	Heart Disease	Yes	No	Rheumatic Fever	Yes	No
Asthma	Yes	No	Hepatitis	Yes	No	Seizures	Yes	No
Back Problems	Yes	No	High Blood Pressure	Yes	No	Stroke	Yes	No
Cancer	Yes	No	HIV/AID	Yes	No	Thyroid Disease	Yes	No
Diabetes	Yes	No	Kidney Disease	Yes	No	Transfusions	Yes	No
Eczema	Yes	No	Migraines	Yes	No	Tuberculosis	Yes	No
Blood Clots	Yes	No	Mitral Valve Prolapse	Yes	No	Ulcers	Yes	No

Other

_____

Hopitalizations & Surgeries:

_____

_____

Medications:_____

_____

_____

Social History: Alcohol yes no occasional Tobacco never smoked used to smoke yes-packs/day_____ smokeless
Recreational Drugs yes no Occupation _____

Family Medical History:
Father:_____
Mother: _____
Sisters: _____
Brothers: _____

Review of Systems: Please indicate any personal history below:

☐ **Constitutional Symptoms**
- Good general health lately ... No Yes
- Recent weight change ... No Yes
- Fever ... No Yes
- Fatigue ... No Yes
- Headaches ... No Yes

☐ **Eyes**
- Eye disease or injury ... No Yes
- Wear glasses/contact lenses ... No Yes
- Blurred or double vision ... No Yes

☐ **Ears/Nose/Mouth/Throat**
- Hearing loss or ringing ... No Yes
- Earaches or drainage ... No Yes
- Chronic sinus problem or rhinitis No Yes
- Nose bleeds ... No Yes
- Mouth sores ... No Yes
- Bleeding gums ... No Yes
- Bad breath or bad taste ... No Yes
- Sore throat or voice change ... No Yes
- Swollen glands in neck ... No Yes

☐ **Cardiovascular**
- Heart trouble ... No Yes
- Chest pain or angina pectoris ... No Yes
- Palpitation ... No Yes
- Shortness of breath w/walking or lying flat ... No Yes
- Swelling of feet, ankles or hands No Yes

☐ **Respiratory**
- Chronic or frequent coughs ... No Yes
- Spitting up blood ... No Yes
- Shortness of breath ... No Yes
- Wheezing ... No Yes

☐ **Gastrointestinal**
- Loss of appetite ... No Yes
- Change in bowel movements ... No Yes
- Nausea or vomiting ... No Yes
- Frequent diarrhea ... No Yes
- Painful bowel movements or constipation ... No Yes
- Rectal bleeding or blood in stool No Yes
- Abdominal pain ... No Yes

☐ **Genitourinary**
- Frequent urination ... No Yes
- Burning or painful urination ... No Yes
- Blood in urine ... No Yes
- Change in force of strain when urinating ... No Yes
- Incontinence or dribbling ... No Yes
- Kidney stones ... No Yes
- Sexual difficulty ... No Yes
- Male - testicle pain ... No Yes
- Female - pain with periods ... No Yes
- Female - irregular periods ... No Yes
- Female - vaginal discharge ... No Yes
- Female - # of pregnancies ... _____
- Female - # of miscarriages ... _____
- Female - date of last pap smear _____

☐ **Musculoskeletal**
- Joint pain ... No Yes
- Joint stiffness or swelling ... No Yes
- Weakness of muscles or joints ... No Yes
- Muscle pain or cramps ... No Yes
- Back pain ... No Yes
- Cold extremities ... No Yes
- Difficulty in walking ... No Yes

☐ **Integumentary (skin, breast)**
- Rash or itching ... No Yes
- Change in skin color ... No Yes
- Change in hair or nails ... No Yes
- Varicose veins ... No Yes
- Breast pain ... No Yes
- Breast lump ... No Yes
- Breast discharge ... No Yes

☐ **Neurological**
- Frequent or recurring headaches No Yes
- Light headed or dizzy ... No Yes
- Convulsions or seizures ... No Yes
- Numbness or tingling sensations ... No Yes
- Tremors ... No Yes
- Paralysis ... No Yes
- Head injury ... No Yes

☐ **Psychiatric**
- Memory loss or confusion ... No Yes
- Nervousness ... No Yes
- Depression ... No Yes
- Insomnia ... No Yes

☐ **Endocrine**
- Glandular or hormone problem ... No Yes
- Excessive thirst or urination ... No Yes
- Heat or cold intolerance ... No Yes
- Skin becoming dryer ... No Yes
- Change in hat or glove size ... No Yes

☐ **Hematologic/Lymphatic**
- Slow to heal after cuts ... No Yes
- Bleeding or bruising tendency ... No Yes
- Anemia ... No Yes
- Phlebitis ... No Yes
- Past transfusion ... No Yes
- Enlarged glands ... No Yes

☐ **Allergic/Immunologic**

History of skin reaction or other adverse reaction to:
- Penicillin or other antibiotics ... No Yes
- Morphine, Demerol, or other narcotics ... No Yes
- Novocain or other anesthetics No Yes
- Aspirin or other pain remedies No Yes
- Tetanus antitoxin or other serums ... No Yes
- Iodine, Merthiolate or other antiseptic ... No Yes
- Other drugs/medications: _____

_____

Known food allergies: _____

_____

Environmental allergies: _____

_____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibilty to inform the doctor's office of any changes in my medical status. I also authorize the healthcare staff to perform the necessary services I may need.

_____ _____

Signature of Patient, Parent or Guardian Date

Doctor's Review

_____ _____

Signature of Doctor Date

WILMINGTON FOOT AND ANKLE, INC.

PATIENT CONSENT FOR USE AND DISCLOSURE
OF PROTECTED HEALTH INFORMATION

I hereby give my consent for Wilmington Foot and Ankle, Inc. to use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). (Wilmington Foot and Ankle, Inc.'s Notice of Privacy Practices provides a more complete description of such uses and disclosures.)

I have the right to review the Notice of Privacy Practices prior to signing this consent. Wilmington Foot and Ankle, Inc. reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Wilmington Foot and Ankle, Inc. Privacy Officer at 630 West Main Street, Suite 203, Wilmington, OH 45177.

With this consent, Wilmington Foot and Ankle, Inc. may call my home or other alternative location and leave a message on voicemail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical can:, including laboratory results among others.

With this consent, Wilmington Foot and Ankle, Inc. may mail to my home or other alternative location any items th.at assist the practice in carrying out TPO. such as appointment reminder cards and patient statements as long as they are marked Personal and Confidential.

I have the right to request that Wilmington Foot and Ankle, Inc. restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement. By signing this form, I am consenting to Wilmington Foot and Ankle, Inc. uses and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, WILMINGTON FOOT AND ANKIE, INC. may decline to provide treatment to me.

_____
Signature of Patient or Legal Guardian

_____ _____
Patient's Name Date

_____
Print Name of Patient or Legal Guardian

Wilmington Foot & Ankle, Inc.

Consent and Release

1. I am consenting to examination and treatment by physicians and allied health professionals employed by Wilmington Foot and Ankle, Inc. I understand that I will not be involved in research or experimental procedures without my knowledge or consent.

2. I am responsible for paying for all services provided to me, which may include collection fees, and agree that any insurance benefits for my account be paid directly to Wilmington Foot and Ankle, Inc. I authorize Wilmington Foot and Ankle, Inc. to submit insurance claims on my behalf. I certify that all information given by me in applying for payment by any third party is true and accurate.

3. I authorize release of my medical bills to the person whose medical insurance is paying all or part of my account.

4. I understand that I may receive separate bills for professional interpretations and/or for hospital outpatient services.

5. I authorize Wilmington Foot and Ankle, Inc. to submit Medicare claims on my behalf and request that payment of authorized Medicare benefits be made directly to Wilmington Foot and Ankle, Inc. for any services provided. Additionally, I authorize release of any medical information regarding my care in order to determine potential payable services.

I authorize Wilmington Foot and Ankle, Inc. to disclose my personal health information to the following individual (s) who are involved in my care:

Printed Name of Individual	Relationship to Patient	Telephone #
Printed Name of Individual	Relationship to Patient	Telephone #

I have been given the opportunity to ask questions about this document. By signing below, I declare that I understand the above information:

Signature of Patient or Representative	Date
Signature of Witness	Date

Office Financial Policies

Authorization/Release Agreement

This agreement authorizes Kimberly L. Seaver, DPM,/John A. Mehnert, DPM to file claims on my behalf with my insurance companies. I authorize and direct my insurance companies to pay claims directly to Kimberly L. Seaver, DPM/John A. Mehnert, DPM for any claims on which she has accepted assignment.

I also authorize Kimberly L. Seaver, DPM/John A. Mehnert, DPM to furnish my insurance company with any medical information the insurance company deems necessary to process my claim(s). I authorize the release of any medical information to my Primary Care Physician in order to provide complete care.

A copy of this can be considered as an original for insurance purposes.

Signed_____Oate_____

Office Financial Policy

I have read and agree to the following:

1. Payments for services not covered by insurance and/or copayments are due at the time of service. If for any reason there is a balance on my account, I agree to pay in full when my first bill is received. For balances over $100.00, payment arrangements may be made with the office at my request.

2. I understand that the office will file insurance claims on my behalf. I understand that follow-up with my insurance carrier regarding unpaid claims is my responsibility. I understand that Dr. Seaver/Mehnert's office will assist me by providing any medical information requested by my insurance carrier regarding my care. I understand that I will receive a monthly statement, and I am responsible for this bill.

3. I understand that it is my responsibility to obtain referral forms required by my insurance carrier and that I am responsible for notifying Dr. Seaver/Dr. Mehnert's office about any prior-authorization or second opinion requirements of my insurance plan.

4. I understand that it is improper for me to keep insurance money intended as payment to this office and
that if I keep these funds for personal use legal action may be taken by this office.

5. I understand that I am responsible for any charges incurred by me or my dependents for all services rendered to me or to my dependents.

6. I understand that 1 will be charged $ 20.00 for a returned check and will be responsible for any charges incurred by this office for accounts sent to collections.

7. I understand that refunds due to me on my account will take a minimum of 3 weeks to process.

Signed:_____Date_____

Witness:_____Date_____