Eastern Carolina Foot and Ankle Specialists
2140 W. Arlington Blvd Suite D, Greenville, NC 27834
(252)830-1000 Fax (252)830-0511

Welcome. Please print your responses to the following questions. This is part of your record.

Full Name ________________________________ Date of Birth ___/___/_____

Address ____________________________ Race _____ Gender M or F Age______

City/State/Zip ________________________________ SSN ____-____-_____

Contact Information Home (____) ____-_____ Cell (____) ____-_____

Email Address: ________________________________

Marital Status Single Married Divorced Widow/Widower

Employer Name ________________________________

Occupation ____________________ Work (____) ____-_____

Emergency Contact Information

Name ________________________________

Relationship ____________________ Phone Number (___) ___-_____

Primary Insurance **Secondary Insurance**

1. ____________________________ 2. ____________________________

If you are on your spouse or parents policy we need their: Name ____________________

Date of Birth ____________________ SS# ____________________

Were you referred by a Physician or friend? If so, who? ____________________

I certify that the above information is true and correct to the best of my knowledge. I hereby give ECFAS permission to administer and perform such procedures as may be deemed necessary to diagnose and/or treat my feet. Also, I understand that photographs may be taken of my feet and are part of my medical record.

______________________________ ____________________

Signature (Signature of Parent or Guardian if under 18 years of age) Date

PATIENT ACKNOWLEDGMENT FORM

Patient Acknowledgment of Understanding of Eastern Carolina Foot and Ankle Specialists Privacy Practice.

Patient's Name: ________________________________ Date of Birth______________

SSN: ____________________ Previous Names: ________________________________

I understand that the patient's health information is private and confidential. I understand that Eastern Carolina Foot and Ankle Specialists works very hard to protect the patient's privacy and preserve the confidentiality of the patient's personal health information.

I understand that ECFAS may use and disclose the patient's personal health information to help provide health care to the patient, to handle billing and payment, and to take care of other health care operations[*In general, there will be no other uses and disclosures of this information unless I permit it. I understand that sometimes the law may require the release of this information without my permission. These situations are very unusual. One example would be if a patient threatened to hurt someone.]

ECFAS has a detailed document called the "Notice of Privacy Practices". It contains more information about the policies and practices protecting the patient's privacy and will be given upon request. I understand I have the right to read the "Notice" before signing this Acknowledgment.

ECFAS may update this Acknowledgement and "Notice of Privacy Practices". If I ask, ECFAS will provide me with the most current "Notice of Privacy Practices".

Within this Notice of Privacy Practices is contained a complete description of my privacy/ confidentiality rights. These rights include, but are not limited to, access to my medical records; restrictions on certain uses; receiving an accounting of disclosures as required by law; and requesting communication be by specified methods of communications or alternative locations.

ECFAS has established procedures which help them meet their obligations to patients. These procedures may include other signature requirements, written acknowledgements, and authorizations; reasonable time frames for requesting information; charges for copies and non-routine information needs; etc. I will assist ECFAS by following these procedures if I choose to exercise any of my rights described in the "Notice of Privacy Practices".

My signature below indicates that I have been given the chance to review a current copy of ECFAS's "Notice of Privacy Practices".

________________________________ ______________

Signature (Signature of Parent or Guardian if under 18 years of age) **Date**

____

Relationship to patient if signed by anyone other than the patient (parent, legal guardian, personal represented, etc.)

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Office Policies

1. I hereby authorize payment of benefits to be made directly to ECFAS unless otherwise specified. **ALL CO-PAYS AND CO-INSURANCE ARE DUE AT THE TIME OF SERVICE.** I recognize and accept **PERSONAL RESPONSIBILITY FOR ANY REMAINING BALANCES NOT COVERED BY MY HEALTH INSURANCE.** If unfortunately it becomes necessary to refer this matter to any outside collection service, I agree to pay all applicable fees.
2. Also, I recognize and accept personal responsibility for any referral needed for my primary care physician, which is required, by my health insurance provider. If this information has not been obtained in accordance to my policy, **I WILL BE FULLY RESPONSIBLE FOR ANY AND ALL SERVICES. FAILURE TO OBTAIN THE REQUIRED INFORMATION WILL RESULT IN RESCHEDULING OF TODAY'S APPOINTMENT.**
3. Medicare Patients– all initial office visits are covered at 80% after your $150 deductible has been met. The remaining 20% may be covered depending on your secondary insurance. This 20% cannot be waived, because the office can be held liable and accused of Medicare fraud if we do not bill you. You should realize that there is usually one fee for the office visit and a fee for any additional care that is provided. Injections are considered surgery, which you may notice on your Medicare Explanation of Benefits.
4. I authorize the release of any medical information about me to the proper agency to determine these benefits if necessary.
5. I authorize the release of any medical or other information necessary to process a claim. I also request payment of insurance benefits be made to Eastern Carolina Foot and Ankle Specialists.

I have read and understand the above information, and agree to these terms.

____________________________________ ____________________

Signature (Signature of Parent or Guardian if under 18 years of age) **Date**

Patient Name:______________________________

Medical Information

Primary Care Providers Name and Address: ____

____

Date of last visit with your PCP: ______ Are your currently under a doctor's care? Yes or No

What is your height? _________ Weight? _________ Shoe Size? _______

Have you had previous treatment by a podiatrist? Yes No When? __/__/_____

For what reason?____

What is the reason for your visit today? ____

What type of pain are you having?____

How long has your problem existed?__________ Was an accident involved, if so when? _______

What have you done for your problem?____

Circle one of the underlined descriptions. Have symptoms been: gradual or sudden? Persistent or come and go? Has the problem become better or worse or stayed the same?

ARE YOU CURRENTLY PREGNANT OR NURSING? Yes No

Do you have or have you had any of the following? Please check all that apply.

___Anemia	___High Blood Pressure	___Skin Rashes
___Arthritis	___High Cholesterol	___Stomach/Intestinal Ulcers
___Asthma	___Kidney Disease	___Stroke
___Bleeding Problems	___Thyroid Disease	___ DVT/ Blood clot
___Blood Disease	___Liver Disease	___Tuberculosis
___ Varicose Veins	___Muscle Disease	___ Breathing/Lung Problems
___Cancer	___Diabetes	___Epilepsy
___Glaucoma	___Heart Trouble	___Sickle Cell
___Pace Maker	___ Heart Attack/ MI	___Rheumatoid Arthritis
___ AIDS/ HIV	Other _______________	___Gout

Does anyone in your immediate family have any of the above conditions? (Please mention)______

____

Is there any family history of foot problems? ____

Allergies

Are you allergic to...

___Novocaine/ Local Anesthetic ___Penicillin ___Sulfa ___Latex

___Adhesive Tape ___Codeine ___Iodine ___Other________________

Do you smoke or have a history of smoking? ________
How many packs per day? ______ How long? _______
Do you use Alcohol or ever used alcohol? _______ How much per week? ______
Do you use street drugs or ever used street drugs? ______
Please name: ________________________

Please list and date any surgeries or hospitalizations you have had: __________________________
____
____

Is there anything else we should know about your general health?___________________________
____

Please list **ALL** medications that you take on a daily basis, how much you take each day and what condition you take the medication for. Please include birth control pills or large dosages of aspirin.

MEDICATION	DOSE	FOR WHAT CONDITION

PLEASE CIRCLE IF THE FAMILY MEMBER IS ALIVE OR DECEASED. LIST ANY MAJOR MEDICAL PROBLEM. PLEASE DO NOT LIST FAMILY MEMBERS NAME

MOTHER	**ALIVE**	**DECEASED**	
FATHER	**ALIVE**	**DECEASED**	
BROTHER	**ALIVE**	**DECEASED**	
SISTER	**ALIVE**	**DECEASED**	
MATERNAL GRANDMOTHER	**ALIVE**	**DECEASED**	
MATERNAL GRANDFATHER	**ALIVE**	**DECEASED**	
PATERNAL GRANDMOTHER	**ALIVE**	**DECEASED**	
PATERNAL GRANDFATHER	**ALIVE**	**DECEASED**	