Foot & Ankle Associates, Inc.

Thomas J. Chambers, DPM
Chad A. Squire, DPM
Jason W. Rockwood, DPM
William J. Blake, DPM
Edward D. Williams, DPM

Patient Information

(Please complete the following and return to receptionist when completed.
If you have any question please ask.)

Today's Date: _____/_____/_____ Date of Birth: _____/_____/_____

Legal First Name: _____ M.I. _____ Legal Last Name: _____

Suffix (Jr., Sr. , III):_____ Social Security Number: _____ Age: _____

Preferred Name: _____ Shoe Size: _____ Height: _____ Weight: _____

Marital Status: ❑Married ❑Single ❑Divorced ❑Separated ❑Widowed ❑Domestic Partnership

Race: _____ Ethnicity: _____ Gender: ❑ Male ❑ Female

Contact Information: Home (____) _____ Work (____) _____Mobile (____) _____

Preferred Contact Method: ❑Home ❑Work ❑Mobile ❑Mail ❑Email

May we leave a message at the preferred contact number above? ❑ Yes ❑ No

Email Address: _____ Receive updates and information? ❑Yes ❑No

Address: _____City: _____ State: _____ Zip Code: _____

Employed: ❑Yes ❑No Employer Name: _____ Occupation: _____

Emergency Contact Name: _____ Relation: _____ Phone #: _____

Primary Care Physician Name: _____ Phone #: _____

Preferred Pharmacy Name: _____ Phone#: _____

Foot & Ankle Associates, Inc.

Thomas J. Chambers, DPM
Chad A. Squire, DPM
Jason W. Rockwood, DPM
William J. Blake, DPM
Edward D. Williams, DPM

In order for us to file a claim on your behalf, we need you to complete this section entirely.

Financially Responsible Party Name (if different from the patient): _____

Address: _____City: _____ State: _____ Zip Code: _____

Contact Information: Home (____) _____ Work (____) _____Mobile (____) _____

Primary Policy Company Name: _____ Plan Type: ❑HMO ❑PPO ❑Other

Policy #: _____ Group #: _____ Effective Date: _____

Primary Insurance Holder Name: _____ Employer: _____

Date of Birth: ____/____/____ Social Security Number: _____ Relation: _____

Secondary Policy Company Name: _____ Plan Type: ❑HMO ❑PPO ❑Other

Policy #: _____ Group #: _____ Effective Date: _____

Secondary Insurance Holder Name: _____ Employer: _____

Date of Birth: ____/____/____ Social Security Number: _____ Relation: _____

How did you hear about Foot & Ankle Associates?

❑Physician Referral Physician's Name_____ Phone #: _____

❑Friend _____ ❑Family _____

❑Website or Email ❑Google Search ❑Phone Book ❑Insurance ❑Newsletter ❑Facebook or Twitter

❑ Other (please specify) _____

Would you be willing to provide a testimonial based on your visit to Foot and Ankle Associates, Inc.?

Please list contact information and we may contact you on ways you can share with others about us.

Name: _____ Email: _____ Phone: _____

Foot & Ankle Associates, Inc.

Thomas J. Chambers, DPM
Chad A. Squire, DPM
Jason W. Rockwood, DPM
William J. Blake, DPM
Edward D. Williams, DPM

Patient Health and History

Legal First Name: _____ M.I. _____ Legal Last Name: _____

What is the reason for your visit to the podiatrist today? _____

Have you been seen by a podiatrist prior to your visit today? ❑ Yes ❑ No

If yes, what was the podiatrist's name? _____ Date of Last Visit ____/_____/____

Please list any medications, including prescriptions, over the counter medication and vitamins: _____

_____

_____

_____

Please indicate if you have had any of the following

- ❑ AIDS/HIV
- ❑ Anemia
- ❑ Angina
- ❑ Ankle Pain
- ❑ Arthritis _____
- ❑ Artificial Heart Valve
- ❑ Artificial Joints
- ❑ Athletes Foot
- ❑ Asthma
- ❑ Back Problems
- ❑ Bleeding Disorder
- ❑ Bunions
- ❑ Cancer _____
- ❑ Chemical Dependency
- ❑ Chest Pain
- ❑ Circulatory Problems
- ❑ Corns and Calluses
- ❑ Diabetes
- ❑ Epilepsy
- ❑ Fainting
- ❑ Fibromyalgia
- ❑ Flat Feet
- ❑ Foot or Leg Cramps
- ❑ Gout
- ❑ Headaches
- ❑ Heart Disease
- ❑ Heel Pain
- ❑ Hemophilia
- ❑ Hepatitis or Jaundice
- ❑ High Blood Pressure
- ❑ Ingrown Toenails
- ❑ Kidney Problems
- ❑ Liver Disease
- ❑ Low Blood Pressure
- ❑ Numbness in feet or Legs
- ❑ Neuropathy
- ❑ Plantar Warts
- ❑ Phlebitis
- ❑ Psychiatric Care
- ❑ Radiation Treatment
- ❑ Rash
- ❑ Respiratory Disease
- ❑ Rheumatic Fever
- ❑ Shortness of Breath
- ❑ Sinus Problems
- ❑ Stroke
- ❑ Swelling in Ankles or Feet
- ❑ Tired Feet
- ❑ Ulcers
- ❑ Varicose Veins
- ❑ Weight Loss, unexplained

Please indicate any allergies to the following:

- ❑ No known Allergies
- ❑ Adhesive Tape
- ❑ Local Anesthetics
- ❑ Iodine
- ❑ Latex

Other: _____

Foot & Ankle Associates, Inc.

Thomas J. Chambers, DPM
Chad A. Squire, DPM
Jason W. Rockwood, DPM
William J. Blake, DPM
Edward D. Williams, DPM

Please list any previous surgeries: _____

_____

Please list any previous hospitalizations: _____

_____

Family History: _____

_____

_____

_____

Please list any physical activities and the frequency: _____

Smoking status? ❑ Every Day Smoker ❑ Occasional Smoker ❑ Non-Smoker ❑ Former Smoker

Do you use recreational drugs? ❑ Yes ❑ No If yes, how frequently? _____ How long? _____

Do you use alcohol? ❑ Yes ❑ No If yes, how frequently? _____ How much? _____

Are you pregnant? ❑ Yes ❑ No

I certify that the above information is true to the best of my knowledge. I hereby consent and give my permission to the doctor (and the doctor's assistants or designated replacement) to administer and perform such procedures upon me as the doctor deems necessary.

Patient or Guardian: _____ Date: _____

Witness: _____ Date: _____

Foot & Ankle Associates, Inc.

Thomas J. Chambers, DPM
Chad A. Squire, DPM
Jason W. Rockwood, DPM
William J. Blake, DPM
Edward D. Williams, DPM

Office Policies and Financial Agreement Form

All patients must read and sign this document

Foot and Ankle Associates, Inc. provide discounts to you and your insurance company in return for keeping all your appointments.

If it is necessary for you to cancel or reschedule an appointment, we require **a full 24 hour notice** to change your appointment without charge. Any appointment cancelled or rescheduled without 24 hour notice will result in charging a $25.00 fee. We reserve the time for you that another person in need of care could have had with the doctor if you provide the required notice. If you are more than 20 minutes late for your appointment, we reserve the right to reschedule if we cannot accommodate you.

If you are a patient who has had a work related, automobile or other accident or injury, it is your responsibility to provide us with the name and address of the responsible insurance companies and your attorney.

The fees for office services, supplements and supports are **payable in full** at the time of your visit unless other arrangements have been made in advance.

I have read, understand and agree to the above policies.

Legal First Name: _____ M.I. _____ Legal Last Name: _____

Patient or Guardian: _____ Date: _____

Witness: _____ Date: _____

Foot & Ankle Associates, Inc.

Thomas J. Chambers, DPM
Chad A. Squire, DPM
Jason W. Rockwood, DPM
William J. Blake, DPM
Edward D. Williams, DPM

Acknowledgement of Receipt of Notice of Privacy Practice and Authorized Disclosure Form

I acknowledge that I was provided a copy of the notice of Privacy Practices and that I have read (or had the opportunity to read if I so choose) and understand the notice.

I give permission for doctors and staff to discuss any information of a medical or financial nature with these people:

Name: _____

Relation: _____

Phone Number: _____

Name: _____

Relation: _____

Phone Number: _____

Name: _____

Relation: _____

Phone Number: _____

Name: _____

Relation: _____

Phone Number: _____

Legal First Name: _____ M.I. _____ Legal Last Name: _____

Patient or Guardian: _____ Date: _____

Witness: _____ Date: _____