Foot & Ankle Centers

The Centers for Foot and Ankle Surgery, LTD

Patient Update

Today's Date _____

In an effort to offer you the highest standard of quality patient care, we require your records be updated if you have not been to our office for one year or more. Please answer the following questions, and thank you for your cooperation.

PLEASE PRINT CLEARLY

Patient Information

Name_____

_____

Street Address Apt. #

_____

City State ZIP

Home Phone _____

Work Phone _____

Cell Phone_____

Preferred method of contact: home# work# cell# (circle one)

Email Address _____

Print please

Patient Occupation _____

Employer Name_____

Employer Address_____

Insurance

Please present Insurance cards at the front desk to be copied.

Primary Policy – Holder's Name_____

Relationship to patient ❒Spouse ❒Parent

Subscriber Date of Birth Mo_____Day_____Year_____

Secondary Policy – Holder's Name_____

Relationship to patient ❒Spouse ❒Parent

Subscriber Date of Birth Mo_____Day_____Year_____

Name of Referring Physician _____

Referral Needed? ❒Yes ❒No

Co-pay? ❒Yes ❒No How much?_____

Deductible?: How much:_____

Preferred Language: _____

Ethnicity: Not Hispanic or Latino❍ Hispanic or Latino❍

Race: American Indian or Alaska Native ❍ Asian ❍

Black of African American ❍ White ❍ Other ❍ Unknown❍

Native Hawaiian or Other Pacific Islander ❍ Hispanic or Latino ❍

Updated Medical Health History

Who is your Primary Care physician? _____

When was the last time you saw him/her? _____

Patient Height _____' _____" Weight_____

Shoe Size_____

Have you had medical health issues in the past year?

❒Yes ❒No If yes, please list any new conditions and the physician whose care you are under for it:

Condition	Physician

Medications / Pharmacy Ph#:_____

Please provide us with an update of ALL medications you are taking. (***If you have a written list, we can copy it to avoid your having to fill out this section***)

Name of Medication	Strength/Mg	Take how often?

Do you have any allergies? ❒Yes ❒No

If yes, what are they? _____

_____

Do you currently use: Cigarettes or Tobacco? Yes ❍ No ❍ Quit ❍

If yes, for how long? _____How many pks/day?_____

If quit, when? _____yrs _____months

Alcohol use? Yes ❍ No ❍ If yes, quantity _____daily _____weekly

Consent to Healthcare Services

I understand the information provided on this form is true and correct to the best of my knowledge.

- I request payments of authorized benefits be made on my behalf for any services furnished by **Centers for Foot and Ankle Surgery, Ltd (dba: Foot & Ankle Centers).**
- I authorize any holder of information about me to release any information needed to determine these benefits or the benefits payable to related services to the insurance agent.
- I recognize my financial obligation of any coinsurance, co-pays or deductibles and non-covered services that may be required.
- I hereby give permission to **Foot & Ankle Centers/ Centers for Foot and Ankle Surgery, Ltd** and any qualified staff to evaluate, diagnose and treat my foot and/or ankle condition as may be deemed necessary.

Patient or Authorized Signature _____ If not patient, state relationship _____

Date _____/_____/_____

Revised 01/15/18ds