QUAD CITIES FOOT & ANKLE ASSOCIATES, P.C.
2332 Cumberland Square Drive, Bettendorf, IA 52722

PATIENT INFORMATION SHEET

Date _____

Patient Name: (First)_____ (MI)_____ (Last)_____ Sex: Male / Female

Social Security #: _____ DOB: _____ Age: _____ E-Mail:_____

Home Address: _____ Unit #: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Mobile Phone: _____

Occupation: _____ Employer / School: _____ Full Time / Part Time (circle)

Work Address: _____ City: _____ State: _____ Zip: _____

Emergency Contact – Name: _____ Relation: _____ Phone: _____

Reason for Today's Visit: _____

Preferred Pharmacy: _____

Language: _____ Height: _____ Weight: _____ Shoe Size: _____

Race (circle one): American Indian Asian Black or African American Native Hawaiian Caucasian

Ethnicity (circle one): Hispanic or Latino Not Hispanic or Latino

Family Medical Doctor (Name, Address, Phone #): _____

Diabetic Doctor (if applicable – Name, Address, Phone #): _____

Date Last Seen (PCP or Diabetic Doctor): _____

Do You Have Health Insurance Coverage? Yes / No If yes, please provide information below. ***(Must present card at check-in or appointment will be rescheduled.)***

Name of Insured Person: _____ Relationship: _____

Social Security # of Insured Person: _____ DOB of Insured Person: _____

Full Name of Primary Insurance: _____

Policy and Other ID #'s: _____

Full Name of Secondary Insurance: _____

Policy and other ID #'s: _____

How did you hear about the practice? (circle one)

- Internet/Google_____
- Friend/Family_____
- Doctor Referral (who?)_____
- Insurance Company_____
- Facebook_____
- Other_____

QUAD CITIES FOOT & ANKLE ASSOCIATES, PC

Medical Health History Form

PLEASE COMPLETE BOTH PAGES AND SIGN THE FORM AT THE BOTTOM, IT IS VERY IMPORTANT TO PROVIDE DETAILED AND ACCURATE ANSWERS TO ALL OF THE QUESTIONS

PAST MEDICAL AND SURGICAL HISTORY: Please circle if you have, or have ever had, any of the following conditions –

AIDS/HIV	CORONARY ARTERY DISEASE	GOUT	MENTAL ILLNESS	RHUEMATOID ARTHRITIS
ANEMIA	DEEP VEIN THROMBOSIS	HEART DISEASE	MYOCARDIAL INFARCTION	SEIZURES/EPILEPSY
ANXIETY	DEPRESSION	HEPATITIS	NEUROPATHY, PERIPHERAL	STROKE
ARTHRITIS	DIABETES	HERNIA	ORGAN TRANSPLANT	SUBSTANCE ABUSE
ARTIFICAL JOINTS	DIALYSIS	HYPERLIPIDEMIA	OSTEOPOROSIS	THYROID PROBLEMS
ASTHMA	EDEMA	HYPERTENSION	PACEMAKER	TUBERCULOSIS
BACK PAIN	ESOPHAGEAL REFLUX	HYPOTHYROID	PERIPHERAL VASCULAR DISEASE	ULCER- (LEG OR FOOT)
BLEEDING DISORDER	FIBROMYALGIA	IRREGULAR HEARTBEAT	PHLEBITIS	
BLOOD CLOT	FOOT DEFORMITY	KIDNEY DISEASE	POLIO	VARICOSE VEINS
CANCER	FROSTBITE	LIVER DISEASE	PULMONARY EMBOLISM	VENOUS STASIS
CONGESTIVE HEART FAILURE	GASTRIC ULCER	LUNG DISEASE	RAYNAUD'S DISEASE	

List any other medical conditions not listed above:

_____ _____

_____ _____

_____ _____

Please list ALL surgeries you've had: ☐ None

_____ _____

_____ _____

_____ _____

MEDICATIONS: Please list ALL medications you currently take, please include the frequency and dosage-

☐ **None**

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

SOCIAL HISTORY:

Alcohol Use (type, amount): _____

Tobacco Use (amount, years used): _____

Caffeine Use(amount):_____

ALLERGIES: Please list any allergies to medications that you have, With the type of reaction caused by the medication-

☐ **No known allergies**

_____ _____

_____ _____

_____ _____

_____ _____

FAMILY HISTORY: Please list any health problems of parents, (if deceased, how), and any medical problems in your family-

Mother: _____

Father: _____

Other Family Members such as Grandparents and Siblings:

_____

PLEASE CONTINUE AND COMPLETE THE SECOND PAGE OF THIS FORM

PLEASE COMPLETE THIS SECOND PAGE AND SIGN THE FORM AT THE BOTTOM, IT IS VERY IMPORTANT TO PROVIDE DETAILED AND ACCURATE ANSWERS TO ALL OF THE QUESTIONS

REVIEW OF SYSTEMS: Please circle if you have any of the following symptoms – please also give a brief description -

Constitutional: fever, recent weight gain/loss, appetite problems _____

Eyes: double vision, blurring, difficulty seeing _____

Ears, Nose, Mouth, Throat: deafness, sinusitis, hoarseness, dizziness _____

Cardiovascular: chest pain, palpitations, calf muscle pain with exercise _____

Respiratory: shortness of breath, wheezing, cough, bloody cough _____

Gastrointestinal: abdominal pain, constipation, diarrhea, rectal bleeding _____

Urologic: pain with urinating, hesitant urination, bleeding, incontinence _____

Gynecologic: Is there any chance you could be pregnant now? **Yes / No (please circle one)**

Skin: persistent rashes or lesions, changes in moles, itching, redness _____

Neurologic: seizures, loss of balance/coordination, weakness, numbness in feet_____

Psychiatric: depression, anxiety, hallucinations, sleep disturbances _____

Endocrine: excessive thirst, excessive urination, heat/cold intolerance _____

Blood and Lymphatic: anemia, bleeding tendencies, swollen nodes _____

Allergic and Immunologic: hives, eczema, persistent itching _____

Musculoskeletal: stiffness, joint pain/deformity, muscle wasting, spine pain radiating to arms or legs, numbness/tingling _____

_____

Other problems not covered above: _____

_____

PATIENTS PLEASE SIGN FORM HERE: **Patient:** _____ **Date:**_____

FOR PRACTITIONER USE ONLY - I have reviewed and updated the above past medical, family and social history with the patient:

Practitioner: _____ Date: _____

Practitioner: _____ Date: _____

Quad Cities Foot & Ankle Associates, P.C.

Thank you for choosing our office for your podiatric healthcare. We are committed to a successful treatment of your medical needs and make you, the patient, our first and foremost concern. As part of our service we try to contain the cost of healthcare and in an effort to do this we have implemented a financial policy.

FINANCIAL RESPONSIBILITY STATEMENT

- If we are a participating provider with your insurance plan we will submit the claim to your insurance company for you. To do this we must have complete and accurate insurance information and a copy of your identification card or claim form. Your insurance policy is a contract between you and your insurance company; therefore you are responsible for payment whether or not your insurance company pays. It is your responsibility to contact your insurance company regarding pre-certifications, required referrals, authorizations, etc. Failure to do so may reduce the amount of benefits paid by your insurance policy and balance will then become your responsibility to pay. **All co-payments must be paid at the time of service.**

- If you do not have insurance or the doctor is not a participating provider with your insurance plan, please be prepared to fully cover the fees for each visit at the time of treatment.

- Payments for the balance due, co-payments, deductibles, etc. are due at the time of service and may be made by cash, check or credit card. There will be a $25 charge for returned checks. Delinquent accounts will be referred for collection at the discretion of the office manager.

- Please be prepared to pay your full co-pay at the time of service. **We do not bill for co-pays.**

- If you have an annual deductible which has not yet been paid in full, then any charges incurred up to that amount are due at the time of your visit.

- The adult or the parent (custodial guardian) accompanying a minor is responsible for payment of services. For unaccompanied minors, non-emergency treatment will be denied unless prior consent from the parent or guardian has been made for the charges and treatment. Young adults (age 18 and over) are legally responsible for their accounts unless a parent accompanies them to the initial appointment and signs this financial agreement, regardless of insurance coverage.

- Orthotics are a non-covered service by some insurance plans. Please check with your insurance company prior to the examination and casting for orthotics to determine your orthotic benefits. A deposit of $100 is requested at the time of the examination and casting. Full payment is due when the orthotics are dispensed.

- For your convenience we make some supplies available for purchase in the office. If you choose to purchase these items, payment is due at the time of purchase. **We cannot bill for these items.**

Release & Assignment of Medical Information

I the undersigned certify that I (or my dependent) have insurance coverage with the above listed agents and assign directly to Quad Cities Foot & Ankle Associates, P.C. all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for any charges whether or not paid by insurance. I hereby authorize the use of this signature on all insurance submissions.

Acknowledgement of Receipt of Notice of Privacy Practices

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 chose) and understand the notice.

I HAVE READ AND AGREE TO THE ABOVE:

SIGNATURE OF PATIENT OR GUARDIAN_____

Date_____