LOUISVILLE FOOT & ANKLE SPECIALISTS

Norton Audubon Hospital
3 Audubon Plaza Dr.,Suite 320
(502) 893-1844

Twin Lakes Regional Medical Center
910 Wallace Ave., Leitchfield, KY 42754
(502) 893-1844

PATIENT INFORMATION

Patient Name

Last _____ First _____ Middle _____ SSN _____

Street _____ City _____ State _____ Zip _____

Birth Date _____ Age _____ Gender: ❑ Male ❑ Female

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

Mobile Phone _____ Home Phone _____ Email _____

Employer _____ Occupation/Position _____

Business Address _____ Business Phone _____

PARTY RESPONSIBLE FOR PAYMENT OF THE ACCOUNT *(Please complete if other than patient)*

Last _____ First _____ Relationship to Patient _____

Street _____ City _____ State _____ Zip _____

Home Phone _____ Employer _____

Occupation/Position _____ Business Address _____ Business Phone _____

PRIMARY INSURANCE INFORMATION

Company _____

Subscriber Name _____

Date of Birth _____ SSN _____

Policy Number _____

Group Number _____

SECONDARY INSURANCE INFORMATION

Company _____

Subscriber Name _____

Date of Birth _____ SSN _____

Policy Number _____

Group Number _____

OTHER INFORMATION

Have you ever been seen by a Podiatrist ❑ Yes ❑ No Podiatrist's Name _____

Emergency Contact Name _____ Emergency Phone _____

Nearest Relative Name _____ Phone _____

Nearest Relative Address _____

How did you hear about Louisville Foot & Ankle Specialists: _____

Patient Name _____

MEDICAL HISTORY

General Health: ❑ Excellent ❑ Good ❑ Fair ❑ Poor Shoe Size: _____ Width: _____

Recent Glucose _____ A1C _____ Height: _____ Weight: _____

Do you currently have, or have you previously had the following? Also indicate if you have a Family History of these conditions.:

	YES	NO	Family History
Anemia	❑	❑	❑
Arthritis	❑	❑	❑
Diabetes	❑	❑	❑
Gout	❑	❑	❑
Hypertension	❑	❑	❑
Stroke	❑	❑	❑

	YES	NO	Family History
Cardiovascular (Heart) Disease	❑	❑	❑
Respiratory (Breathing) Problems	❑	❑	❑
Gastrointestinal (Stomach) Distress	❑	❑	❑
Urinary (Kidney) Problems	❑	❑	❑
Bleeding Disorders	❑	❑	❑

Please specify _____

_____

What is the foot/ankle condition that you brings you to our office? Please explain: _____

_____

_____

What side and where do you have pain or problems: right / left / both sides and where specifically: _____

How long has this been an issue? _____

Is it getting worse, getting better or staying the same? _____

Describe how it feels: _____

What makes it worse / better? _____

What self-treatment, medical care or surgery have you had? _____

_____

Have you ever been treated for infectious disease (HIV, Hepatitis, MRSA, etc)? ❑ Yes ❑ No

Are you pregnant? ❑ Yes ❑ No

Do you smoke? ❑ Yes ❑ No How many packs per day _____, for how many years _____?

Do you drink alcohol? ❑ Yes ❑ No Do you use illegal drugs? ❑ Yes ❑ No

What medications are you taking? _____

_____

Medication Allergies _____ Other Allergies _____

Are there any other medical conditions we should be aware of? *(Specify)* _____

Family Doctor _____ Pharmacy _____

Date last seen _____ Pharmacy Phone _____ Zip _____

Patient Name _____

- I hereby request and give permission to Louisville Foot & Ankle Specialists and whomever Louisville Foot & Ankle Specialists may designate as assistants, to administer treatment, and to perform such general procedures as Louisville Foot & Ankle Specialists may deem to be necessary in the diagnosis and/or treatment of my foot complaints.
- **AUTHORIZATION:** I hereby authorize the release of any medical information necessary to process my insurance. I authorize payment directly to the provider of services. I understand that I am financially responsible for any remaining or unpaid balances.
- I further authorize the release of any medical information to other doctors treating me.
- I further authorize payment of Medicare and/or other insurance benefits to Louisville Foot & Ankle Specialists for the services performed.
- I give my consent to have photographs and/or videotaped images taken for teaching purposes, advertising and digital/print publication. If utilized, the patient name and all identifiers will be kept confidential.
- I acknowledge that I will be provided a copy of the Notice of Privacy Practices (if requested) and that I understand this notice. This notice may be found at: LouisvilleFootAndAnkleSpecialists.com.
- I give my consent for the practice to contact me at the address /and or phone number provided. Voicemail and text messages may be utilized.

NOTICE OF CANCELLATION POLICY

- I understand that I am responsible for my appointment time(s) and that should I not give notice of cancellation of my appointment at least 24-hours before that appointment, I may be charged a $25.00 fee.
- After two *no-show*s, the practice reserves the right to no longer schedule future appointments.
- These policies are to allow our office to run more efficiently and on time.

_____ _____

Patient Signature Date and time

_____ _____

Parent or Authorized Representative *(if applicable)* Witness