OKLAHOMA
FOOT & ANKLE
ASSOCIATES

Circle which doctor you're seeing today: Bean Carro Morris Walker

First name: _____ Last name: _____ M.I.
What do you like to be called? _____ Birthdate: _____ Age: _____ Gender: M F
Home Address: _____ City: _____ Zip: _____
Mailing Address: _____ City: _____ Zip: _____
(If different from above)
SS#: _____
Home Phone #_____ Work #: _____ Cell#_____
E-mail address: _____ How do you prefer to be contacted? Home Work Cell Email

The following three questions are required by the government: Race: _____ Ethnicity: _____
Preferred Language: _____ ☐ I do not wish to answer these questions.

Your Employer: _____ Occupation: _____
Marital Status: S M W D Spouse's Name: _____
Emergency contact: _____ Relationship: _____ Phone #: _____

Who is your **Primary Care Physician**? _____ Last Date Seen: _____
What **Pharmacy** do you use? _____ Location: _____ Phone #: _____

If patient is a minor, please list name of **responsible party (parties)** and relationship to minor:

_____

Is your visit due to a **motor vehicle accident/personal injury** or an **on the job injury** in which you are using workers compensation coverage/insurance? ☐ Yes ☐No (If yes, please list coverage: _____
_____)

How did you hear about us? _____

If referred, whom may we thank for your referral? _____

BILLING INFORMATION: If patient is **not** the primary insured, please complete information below:
Relationship to Patient: ☐Spouse ☐Parent ☐Divorced Parent ☐Other_____
Name of Insured: _____ Insurance Co: _____
Birthdate: ___/___/___ Insurance ID#: _____ Group ID#: _____
Address: _____ City: _____ Zip: _____ Phone: _____
Employed by: _____ Work #: _____

I authorize treatment and diagnostic procedures to be performed by physician and by members of the staff. I authorize Oklahoma Foot and Ankle Associates to furnish my insurance company, Medicare, referring physician, or other professional agencies, who are concerned with my health and welfare, with all the necessary information regarding my present illness or injury. I also authorize and assign payment of medical benefits to Oklahoma Foot and Ankle Associates for medical services or supplies provided with the understanding that any overpayment due will be reimbursed to me. A photo copy or scan of this authorization shall be considered as effective and valid as the original. I certify that all information contained on this form is true and correct to the best of my knowledge.

Signature: _____ **Date:** _____
(Patient / Responsible party)

Oklahoma Foot & Ankle Associates

Medical Information (Page 1 of 2) Name:_____ Date:_____

Describe your foot or ankle problem(s):_____

_____

How long has it been bothering you? _____

Please list any treatment for this condition (by you or a doctor): _____

_____

Please list any past problems or injuries with your feet or ankles: _____

_____

How much time each day are you on your feet? _____ Do you exercise?_____

Medical History and Ongoing Conditions: Please print list medications, dosages, and medical conditions:

(If you have a list of your medications, please let us copy it.)

Medication & Dosage	**For what condition?**	**Medication & Dosage**	**For what condition?**
•		•	
•		•	
•		•	
•		•	
•		•	

Please list any **Specialists** you see (First and Last name if known):_____

_____

Review of Organ Systems: Please **circle** if you have been told you have or had any of the following:

Blood
- *Anemia*
- Bleeding disorders
- *Blood Clots*
- *Cancer-*
  - *What type?*_____

Musculoskeletal
- *Gout*
- *Osteoarthritis*
- *Rheumatoid Arthritis*
- Other arthritis _____
- Joint Stiffness
- Joint Swelling
- Leg Cramps
- Joint Pain
- Back Pain
- *Sciatica*
- Hip Pain
- Knee Pain
- Nighttime burning - feet
- Cramps of feet

Neurological
- Neuropathy – feet
- Numbness
- *Stroke*
- Paralysis
- Seizures/Epilepsy
- *Migraine Headaches*
- *Multiple Sclerosis*
- *Cerebral Palsy*
- Nervous Disorder

Peripheral Vascular
- Poor Circulation
- Impotence
- Calf Pain when walking
- Varicose Veins
- *Phlebitis*
- Swelling in the legs/feet

Psychology
- *Depression/Anxiety*
- Sleep Disturbances
- Psychiatric Care

Head
- Hearing Loss
- *Macular Degeneration*
- *Cataracts/Glaucoma*

Cardiac
- *Congestive Heart Failure*
- *Heart Disease*
- *High Blood Pressure*
- *Heart Attack (Previous)*
- Irregular Beats
- Murmur
- *Clogged Arteries (Stent)*
- *Pacemaker/Defibrillator*

Endocrine
- Diabetes
- How long? _____ yrs.
- Insulin? ☐ Yes ☐ No
- *Hypoglycemia*
- *Hyperthyroid*
- *Hypothyroid*
- *Osteoporosis*

GI
- *Intestinal disease*
- *Stomach Ulcers*
- *Reflux Disease/GERD*

Kidney
- *Kidney Disease/Failure*
- *Kidney Stones*
- *Dialysis*

Liver disease
- *Hepatitis*
  - *Type?*_____
- *Cirrhosis*

Skin
- Slow healing
- Keloid/Thick Scar
- *Psoriasis*
  - *Type?* _____
- Changing skin lesion
- *Skin Cancer*
  - *Type?* _____

Respiratory
- Lung Problems
- *Asthma*
- *Bronchitis*
- *Emphysema*
- *Pneumonia*
- *Pulmonary Embolism*

Infectious
- *Aids/HIV*
- *Polio*
- *Tuberculosis*
- *Lyme's Disease*

Other Problems not listed?_____

_____

_____

Medical Information (Page 2 of 2) Name:_____ Date:_____

Allergies: Are you **allergic** or **sensitive** to any medications (or anything else?)
(Please list what it was and your reaction to it.)

		Mild	Moderate	Severe
Antibiotics	☐ **Yes** ☐ **No**			
	☐ Penicillin_____	☐	☐	☐
	☐ Sulfa _____	☐	☐	☐
	Others: _____	☐	☐	☐
Aspirin	☐ **Yes** ☐ **No**_____	☐	☐	☐
Ibuprofen (Advil)	☐ **Yes** ☐ **No**_____	☐	☐	☐
NSAIDS	☐ **Yes** ☐ **No**_____	☐	☐	☐
Medicines	☐ **Yes** ☐ **No**_____	☐	☐	☐
	_____	☐	☐	☐
Codeine/Lortab	☐ **Yes** ☐ **No**_____	☐	☐	☐
Local anesthetics	☐ **Yes** ☐ **No** (☐ **Only at the Dentist**) _____	☐	☐	☐
Tape	☐ **Yes** ☐ **No**_____	☐	☐	☐
Betadine (iodine)	☐ **Yes** ☐ **No**_____	☐	☐	☐
Latex	☐ **Yes** ☐ **No**_____	☐	☐	☐
Other	☐ **Yes** ☐ **No**_____	☐	☐	☐
	_____	☐	☐	☐

Surgical History

Please list any **Surgeries** you have undergone: _____

_____

Any problems with **Anesthesia** during surgery? ☐ **Yes** ☐ **No** - If Yes, please list problem:_____

_____

Family History

Please list any **Family medical problems**: Grandparents:_____

Mother:_____ Father: _____

Siblings: _____

Social History

Do you smoke ? ☐ **Yes** ☐ **No** ☐ **Never** Packs per day? _____ How long? _____ Quit?_____

Do you drink alcohol? ☐ **Yes** ☐ **No** If yes, what type and how much per week? _____

Take illegal drugs? ☐ **Yes** ☐ **No** Any problems with addiction / alcoholism ? ☐ **Yes** ☐ **No**_____

Shoe Size: _____ **Current Weight:** _____ **Height:** _____

Any additional information you would like us to know? ☐ **Yes** ☐ **No** - If yes, please list:

_____

This information is correct to the best of my knowledge: _____

Signature **Date**

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NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPPA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I acknowledge that I have received your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

_____ _____

Patient's Name/Responsible Party Date

I give authorization to release my information to:

_____ _____

Name of Person to release to Relationship to Patient

_____ _____

Name of Person to release to Relationship to Patient

_____ _____

Name of Person to release to Relationship to Patient

_____ _____

Name of Person to release to Relationship to Patient

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FINANCIAL POLICY

Thank you for choosing us as your health care provider. We are committed to your treatment being successful. The following is a statement of our Financial Policy which we require you read and sign prior to any treatment. Please understand that payment of your bill is considered your responsibility.

All patient must complete our Information and Insurance form before seeing the doctor.

****FULL PAYMENT IS DUE AT THE TIME OF SERVICE**
****WE ACCEPT CASH, CHECK, VISA/MASTERCAR, AMERICAN EXPERSS AND DISCOVER**

REGARDING INSURANCE

We may accept assignment of insurance benefits. However, we do require a portion of the bill at the time of service. The balance is your responsibility whether your insurance company pays or not. We cannot bill your insurance company unless you give us your insurance information. Your insurance policy is a contract between you and your insurance. We are not a party in that contract. Please be aware that some, and perhaps all, of the services provided may be non-covered services and not considered reasonable and necessary under the Medicare program and/or other medical insurance companies.

Regarding insurance plans where we are a participating provider: All co-pays and deductible are due the day of treatment. In the event that your insurance coverage changes to a plan where we are not a participating provider please refer to the above paragraph.

USUAL AND CUSTOMARY RATES

Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary.

ADULT PATIENT

Adult patients are responsible for full payment at the time of service.

MINOR PATIENTS

The adult accompanying a minor and the parents (or legal guardian of the minor) are responsible for full payment. For unaccompanied minors, non-emergency treatment will be denied unless charges have been paid by Visa/MasterCard, American Express, Discover, Personal check or Cash at the time services are rendered.

REGARDING X-RAYS

The fee you pay for x-rays is for **processing and primary interpretation**, not for the actual copy. Should you need copies of your x-rays taken in this office, please make your request to the nurse.

I have read the Financial Policy. I understand and agree to this Financial Policy:

X _____ **DATE:** _____
(SIGNATURE OF PATIENT OR RESPONSIBLE PARTY)

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NOTICE OF POSSIBILITY OF INSURANCE DENIAL

FOR DURABLE MEDICAL EQUIPMENT

Your insurance company will only pay for a service that it determines to be reasonable and necessary. If your insurance company determines that an item or service is not reasonable and necessary under your insurance program standards, they will deny payment for that item or service. It is possible that your insurance company may deny payment for **DURABLE MEDICAL EQUIPMENT**. Examples of **DURABLE MEDICAL EQUIPMENT** include, but are not limited to:

- Ankle Braces
- Night Splints
- Removable Walking Boots
- Orthotics
- TENs units

Even if your doctor feels you need this DURABLE MEDICAL EQUIPMENT for proper healing of your condition, your insurance company may consider the above item not medically necessary, or they may consider it a non-covered item under your plan policy.

I've have been informed by my physician that in my case, my insurance company may deny payment for the services identified above, for the reasons stated. If my insurance company denies payment, I agree to be personally and fully responsible for payment.

Patient Name: _____

Patient Signature: _____

Date: _____

600 W. 15th Street, Edmond, OK 73013

3001 S. Telephone Rd, Suite B, Moore, OK 73160

1342 S. Douglas, Suite A, Midwest City, OK 73130

520 S. Mustang Road, Yukon, OK 73099