Alabama Foot Institute

Surgery, Medicine & Biomechanics of the Foot

2000 Stonegate Trail
STE 112
Vestavia Hills, AL 35242
205-599-5811

Name _____ Date _____
FIRST MIDDLE LAST

Address _____

City _____ State ____ Zip _____

Home Phone _____ Work Phone _____

Cell Phone _____

Email: _____

Date of Birth _____ Age ____ S.S.# _____

Place of Employment (Name/Address) (If Minor-Parents)

_____

_____

Marital Status (circle): Married, Divorced, Single, Widowed

If You Are A Minor, Parent's Name _____

Primary Care Physician _____ Phone # _____

Physician's Address _____

Emergency Contact _____ _____ Relationship _____ Phone# _____

INSURANCE

Please give card to receptionist to copy.

If policy holder is different from patient, the holder's S.S# and DOB must be completed.

Primary Insurance _____

ID Number _____

Group Number _____

Policy Holder's Name _____

Date of Birth - Policy Holder ___/___/___

S.S.# - Policy Holder _____

Secondary Insurance _____

ID Number _____

Group Number _____

Policy Holders's Name _____

Date of Birth - Policy Holder ___/___/___

S.S.# - Policy Holder _____

Authorization Statement

"I authorize Dr. Todd Falls to render all medically necessary treatment, both medical and surgical, to myself. I request that payment of authorized insurance benefits be made to myself, Dr. Falls for all services furnished to me by that physician on my behalf. I also authorize the release of medical information to physicians and /or insurance agencies as deemed necessary by Dr. Falls."

Signature of patient _____ Date _____

Medicare Authorization Statement

"I authorize Dr. Todd Falls to render all medically necessary treatment, both medical and surgical, to myself. I request that payment of authorized Medicare benefits be made to myself or on my behalf, Dr. Falls for any services furnished to me by that physician or any supplier. I authorize any holder of medical information about me to be released to the health care financing administration and its agents any information needed to determine these benefits or the benefits payable for related services."

Signature of patient _____ Date _____

ALABAMA FOOT INSTITUTE

NAME _____

DATE _____
SS # ____ - ____ - ____
DOB ____ - ____ - ____

Have you or your parent's had: (please circle)

	YOU		MOTHER	FATHER
Diabetes	yes	no	yes	yes
(if yes do you take insulin or pills)				
High Blood Pressure	yes	no	yes	yes
Rheumatic Fever	yes	no	yes	yes
Mitral Valve Prolapse	yes	no	yes	yes
Heart Attack	yes	no	yes	yes
Hepatitis	yes	no	yes	yes
TB	yes	no	yes	yes
Stroke	yes	no	yes	yes
Phlebitis	yes	no	yes	yes
HIV	yes	no	yes	yes
Blood Clots	yes	no	yes	yes
Gout	yes	no	yes	yes
Cancer	yes	no	yes	yes
Anemia	yes	no	yes	yes
Sickle Cell Trait	yes	no	yes	yes
Sickle Cell Disease	yes	no	yes	yes
Lupus	yes	no	yes	yes
Painful Scars	yes	no	yes	yes
Dialysis	yes	no	yes	yes

OCCUPATION: _____

Do you smoke? _____ How much and how often? _____

Do you drink? _____ How much and how often? _____

Pharmacy Name: _____ Location: _____

Pharmacy Phone # _____

ARE YOU ALLERGIC TO: (circle if YES)

Penicillin

Sulfur

Local Anesthetics

Tape

Iodine

Other: _____

_____

_____

CURRENT MEDICATIONS:

(List name and dosage)

_____

_____

_____

_____

_____

PLEASE CONTINUE TO PAGE 2

PAGE 2 History and Physical

NAME _____ DATE OF BIRTH _____

Height: _____ Weight: _____

Previous Surgeries (other than to the foot):

_____

_____

_____

Previous Foot Surgeries (please list type / date / physician):

_____

_____

_____

REASON FOR TODAY'S VISIT:

_____

_____

_____

_____

Reviewed by: _____

PODIATRIC ASSISTANT or PHYSICIAN

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Financial Policy

Payment is expected at the time services are rendered. We will be happy to file your claim as a courtesy with all active insurance carriers. You are responsible on the same day of your visit for any co-pays and deductibles. In addition, it is your responsibility to inform us if a referral is required for your visit. If a referral is required with your plan and you are seen without a valid referral, you accept full responsibility for any charges.

The trimming of toenails, corns, or calluses may or may not be covered under your insurance policy. This serves to acknowledge that you have been informed that these and other services may not be covered under your plan and you may be billed for them.

There is a charge of $30.00 per form for the completion of disability, family leave, medical review or any other form that you or your insurance company may require.

A re-billing fee of $25.00 may be assessed to your account after 25 days of a balance being un-paid unless suitable payment arrangements have been made. Additional collection charges will be assessed if your account requires placement with a collection agency.

I acknowledge that I have reviewed the above policy and agree to the terms. I also agree to be responsible for any and all charges and fees. I agree to pay costs of collection, including attorney's fees, and I waive my exemption under the Constitution and laws of the State of Alabama.

Signed: _____ Date: _____

Print Name: _____

Date of Birth: _____

ACKNOWLEDGEMENT OF RECEIPT

OF

NOTICE OF PRIVACY PRACTICES

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

_____

Patient Name (**please print**) Date

_____

Signature

_____

Parent or Authorized Representitive (**if applicable**)