Queen City Foot & Ankle Specialists

Patient Information

Patient Name:
First: _____ Middle: _____ Last: _____

Sex: Male Female Date of Birth: _____/_____/_____ SSN: _____

Address: _____

City_____ State_____ Zip: _____

Home Phone #: _____ Work #: _____ Cell #: _____

Email _____

Race (**circle** your response): American Indian Asian Black/ African American White Native Hawaiian/ Other

Ethnicity (**circle** your response): Non-Hispanic/Latino Hispanic/ Latino

Primary Language: _____ Do you need an Interpreter? Yes / No

Marital Status (**circle** your response): Divorced Married Partner Single Unknown / Other Widowed Legally Separated

How did you hear about our office? (circle all that apply)

Direct Mailing Friend Insurance Company Internet Newspaper Another Patient Doctor/HealthCare Provider Other

Name of referral source: _____

Primary Care / Referring Physician: _____ / Practice Name: _____

Emergency Contact Name: _____ Phone_____

Pharmacy Name: _____ * **We send all prescriptions electronically**

Location: _____ Phone Number: _____

HIPPA Acknowledgment: I hereby acknowledge that I have been made aware that Queen City Foot and Ankle Specialists (QCFAS) has a privacy policy in place in accordance with the Health Insurance Portability and Accountability Act of 1966 (HIPPA) and has made this policy available to me. I am entitled to a copy of the privacy policy upon request.

How may we contact you? : Phone Mail E-mail Is it ok to leave a message with anyone other than yourself? Yes or No

(Examples would include, but are not limited to, spouse, domestic partner, adult children, and parents).

Print name of individual(s) _____

I authorize the release of any previous exams, results or images in the event QCFAS is in need of them to help with the diagnosis or treatment of my conditions. I permit a copy of the authorization to be used in place of the original. I understand and acknowledge that I am personally responsible for the services rendered at this facility. QCFAS will bill my insurance carrier as a courtesy. In the event of non-payment, I understand I will be responsible for any outstanding balances.

I authorize QCFAS (Dr. Roxanne Burgess, whomever they designate) to examine, administer treatment and to perform such general procedures as she (they) may deem necessary in the diagnosis and/or treatment of my condition(s). I further certify that to the best of my belief and acknowledge the information provided on my personal health history is true, accurate and complete. I also authorize the physician designated to release information acquired in the course of my examination and treatment.

Signature **X** _____ Date_____

Printed Name of Patient or Guardian_____

Medication History

- Please list **all medications, herbal supplements, and over the counter medications** that you are currently taking:

  _____

  _____

  _____

  _____

  _____

- Please list any drug **allergies** you have and the reaction you experienced:

_____

_____

- Are you sensitive to Tapes or Adhesives?: Yes or No
- Do you have any problems taking Aspirin or Ibuprofen (Aleve, Motrin, Advil?: Yes or No

  If yes, please describe: _____

Family Medical History

List any of your immediate **blood relatives** (Mother, Father, Siblings) who have been diagnosed with the following conditions?

Arthritis_____ Cancer Type _____

Stroke_____ Heart Disease/attack_____

Diabetes_____ High Blood Pressure_____

- Are all of your immunizations up to date?: Yes or No
- Have you had a current flu shot?: Yes or No
- Are you pregnant or breastfeeding? Yes or No

List any exercises or athletic activities you are active in_____

Reason for your visit: _____

Percentage of waking hours you spend on your feet (circle one)
10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

Do you have (Please circle) Artificial Joints, Replacement heart valves, or other implants

Social History

Are you a student? Yes, Part time Yes, Full Time No, not Currently a Student

Are you employed? Yes, Part Time Yes, Full Time No, Not Currently Employed

Employer (Company Name):_____ Occupation: _____

- Do you currently smoke or chew tobacco? Yes or No If no, have you in the past? Yes or No

  How many packs per day? _____
- Do you drink alcohol, beer or wine? Yes or No If no, have you in the past? Yes or No

  How many drinks per week? _____

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Your Height_____ **Your Weight**_____ **Your Shoe Size**_____

Past Medical History

Anxiety	Depression	Migraines
Autism	Dementia	Mental Disease
Asthma	High Blood Pressure	Warts
Anemia	High Cholesterol	Neuropathy
Arthritis	Heart Conditions	Liver Disease
Acid Reflux (GERD)	Heart Attack	Osteoporosis
Blood Clot	HIV/AIDs	Poor Circulation
Bi – Polar	Hepatitis Type _____	Nerve Disorder
Bone Spurs	Stroke	Keloid/Thick Scar
Carpal Tunnel	Phlebitis	Thyroid Disorder
Diabetes	Gout	Tuberculosis
Stomach Ulcers	Lung Disease	Dialysis
Kidney Disease	Neuropathy	Spinal Problems
Epilepsy/Seizures	Psychiatric Disorder	Cancer _____
Eczema	Glaucoma	

Other(s) _____

None of the above_____

- **Please list your past surgeries with the date:**

_____

_____

_____

Current Symptom Review:

Fever	Diarrhea	Fatigue	Numbness	Shortness of Breath
Dizziness	Rash	Muscle Pain	Cold Hands/Feet	Painful/Frequent Urination
Nausea/Vomiting	Hives	Bone Pain	Burning	
Chest Pain	Itchy Skin	Neck Pain	Tremors	
Swelling	Itchy Scalp	Back Pain or Injury	Difficulty Breathing	

- Do you have a Health Care Power of Attorney? Yes or No

If yes, please provide the following information:

Name: _____ Date of Birth: _____

Address: _____ Phone: _____

Queen City Foot and Ankle Specialists
Office & Financial Policies

Our goal is to provide and maintain a good physician-patient relationship. Letting you know in advance of our financial and office policies allows for a good flow of communication.

Prescription Refills

For medication refills, we require a notice of 2 business days. Please plan accordingly. **Initial** _____

Insurance Plans

We respectfully request that you keep us updated with your current insurance information. If you change insurance companies or if there is a change to your current insurance coverage, please present your card to us so that we may obtain a copy of it. If the insurance company you designate is incorrect, you will have 14 business days to provide with a copy of the correct insurance card. **If the correct card is not provided to us within 14 business days, we reserve the right to hold you financially responsible for the charges incurred.** **Initial** _____

Financial Responsibility

1. According to your insurance plan, you are responsible for any and all **co-payments**, **deductibles**, and **coinsurances**.
2. **Co-payments** are due at the time of service. A **$5 service fee** will be charged in addition to your co-payment if the co-payment is not paid by the end of the next business day.
3. Self-pay patients are expected to pay for services in **FULL** at the time of the visit.
4. If previous arrangements have not been made with our billing department, any account balance over 90 days old will be forwarded to a collection agency.
5. Any account balance over 90 days old that has to be forwarded to a collection agency will be assessed a service fee of 35% of the total balance.
6. We accept cash, Visa, and MasterCard in our office.
7. Checks will **only** be accepted for payment on invoices you have received from our office. A **$20 fee** will be charged for any checks returned for insufficient funds. **Initial** _____

Forms

If you have any workers compensation, disability, or FMLA papers to be filled out, there is a **$5** charge per form. Payment is due when the forms are dropped off. We have a 3 to 5 business day turn around time for forms. If a form is needed sooner than 3 business days, there is an additional **$15 rush fee per form.** **Initial** _____

I have read and understand the office and financial policies. I agree to comply and accept the responsibility for any payment that becomes due as outlined previously.

Printed Patient Name _____ Date _____

Signature of Patient or Responsible Party _____

Relationship_____

Welcome To Our New Patients

Welcome to our practice! We appreciate the opportunity to be of service to you and hope that you will be pleased with our services. We strive to not only meet, but exceed your expectations on every level.

Queen City Foot & Ankle Specialists is a division of the NC Podiatric Physicians and Surgeons Group, PLLC (NCPPSG). We have divisions across the state, and we operate under one tax id number. As such, if you **have** seen any of the physicians listed below since **January 1, 2013**, we need to know so that we will not file a new patient code for your visit today. Since the insurance carriers look at the NCPPSG as one large practice, if you have been seen at any of the following divisions, you will not be considered a new patient in our practice. In order to ensure that we properly code your visit for today, please indicate if you have been seen at any of the following locations since **January 1, 2013**. **Visits before 2013 do not need to be disclosed to us**.

Please review the names of the divisions and podiatrists below and indicate if you have been seen at of these divisions by putting a on the line to the left of the practice name. Thank you for disclosing this information to us – it will allow us to be in compliance with nationally mandated correct coding initiatives.

	Division	Podiatrist(s)
__	Alta Ridge Foot Specialists	Dr. Robert van Brederode and Dr. William Broyles
__	Ankle & Foot Center of Charlotte	Dr. Scott Basinger
__	Brunswick Foot & Ankle Surgery, P.A.	Dr. Joseph Kibler
__	Carmel Foot Specialists	Dr. Barbara Kaiser, Dr. Richard Lind, Dr. Richard Miller, Dr. Kevin Molan
__	Carolina Foot Care Associates, PLLC	Dr. Ashma Davidson, Dr. Terry Donovan, Dr. William O'Neill
__	Central Carolina Foot & Ankle Associates	Dr. Brian Futrell, Dr. Melissa Hill, Dr. John Iredale
__	Chapel Hill Foot & Ankle Associates, P.A.	Dr. Nicholas Adams, Dr. Jane Anderson, Dr. Alan Bocko
__	Charlotte Foot & Ankle Specialists, PLLC	Dr. Kristine Strauss
__	Comprehensive Foot & Ankle Center, P.A.	Dr. Zack Nellas
__	Crystal Coast Podiatry	Dr. Thomas Bobrowski
__	Eastover Foot & Ankle, P.A.	Dr. Chris Fuesy, Dr. Ron Futerman, Dr. Kent Picklesimer
__	Family Foot & Ankle Center, P.A.	Dr. Patrick Dougherty, Dr. Doug Smith
__	Family Foot Care	Dr. Kevin McDonald, Dr. Tori Simmons-Lewis
__	Foot & Ankle Center of Durham	Dr. Eric Simmons
__	Foot & Ankle of the Carolinas, PLLC	Dr. Eric Ward, Dr. Blaise Woeste
__	Gaston Foot & Ankle Associates, P.A.	Dr. David Kirlin, Dr. Ryan Meredith, Dr. Wagner Santiago
__	Greensboro Podiatry Associates, P.A.	Dr. Martha Aljouny, Dr. N'Tuma Jah
__	Hendersonville Podiatry	Dr. Russ Barone, Dr. Pam Stover
__	James Mazur, D.P.M., P.A.	Dr. James Mazur
__	Matthews Foot Care	Dr. Brian Killian, Dr. Kevin Killian
__	Mt. Airy Foot & Ankle Center, PLLC	Dr. Jim Shipley
__	Piedmont Foot & Ankle Clinic	Dr. Rick Hauser, Dr. Rob Lenfestey, Dr. Jason Nolan, Dr. Joel Kelly
__	Salem Foot Care	Dr. Walter Falardeau
__	Wake Foot & Ankle Center	Dr. Mike Hodos, Dr. Jim Judge
__	Wilson Podiatry Associates, P.A.	Dr. Kendall Blackwell

_____ I attest that I **have** **been** seen in the above indicated division of the NCPPSG since January 1, 2013.

_____ I attest that to my best recollection, I have **NOT** been seen by any of the above divisions since January 1, 2013.

_____ _____

Signature of Patient or Guardian **Date**

_____ _____

Printed Name **Relationship to Patient**

_____

Patient Date of Birth