Premier Foot & Ankle

821 S. Horner Blvd , Sanford, NC 27330
Phone (919- 292-1610 Fax (919) 292-1613
Dr. Ronald M. Talis DPM, FACFAS Dr. Elene Papakostas, DPM Dr. Brandon Bottini, DPM

First: _____ **Last**: _____**(MI)** _____ **Birthdate**: _____/_____/_____

SSN: _____ **Gender**: Male or Female **Age**: _____

Address: _____

City: _____ **State**:_____ **Zip**:_____

Home Phone:_____ **Cell**: _____ **Work**:_____

Email: _____ **Emergency Contact & Phone**: _____

Employer: _____ **Occupation:** _____

Pharmacy:_____ **Number:** _____

Primary care doctor: _____ **Last Seen:** _____

⇒ **Chief foot/ ankle/ leg complaint today**? _____

⇒ **How long has it been bothering you**? _____

- Date of injury if applicable? _____

⇒ **Previous treatments**? _____

_____

MEDICAL HISTORY (Check all that apply)

__ AIDS/HIV	__ Acid Reflux (GERD)	__ Epilepsy	__ Shortness of Breath	__ High Blood Pressure
__ Anemia	__ Blurry Vision	__ Gout	__ Stroke	__ Heart Palpitations
__ Arthritis	__ Cholesterol	__ Joint Pain	__ Stomach Ulcers	__ Heart Disease
__ Asthma	__ Chest Pain	__ Hepatitis	__ Tuberculosis	__ Heart Valve Replacement
__ Anxiety	__ Chronic Headaches	__ Varicose veins	__ Thyroid	__ Joint Replacement
__ Depression	__ Kidney Disease	__ Liver Disease	__ Cancer/Type? _____	

- Are you currently pregnant or breastfeeding? _____
- Are you **DIABETIC**? YES or NO
  IF YES, what was your last HbA1c? _____ *Morning Fasting Blood Sugar*? _____ *Last blood test?* _____
  CIRCLE TYPE OF TREATMENT(S): *Insulin* *OR* *Pills*
- Have you had any previous ulcers? [LIST WHEN AND WHERE] _____

__ **OTHER** medical condition(s) NOT listed: _____

Family History	Social history			
☐ Limb Loss	**Marital Status**	**Alcohol**	**Recreational Drugs**	**Nicotine**
☐ Diabetes	☐ Single	☐ Never	☐ No	☐ Never
☐ Heart Disease	☐ Married	☐ Rare	☐ Yes	☐ Former, quit in _____
☐ Cancer	☐ Divorced	☐ Occasional	List: _____	☐ Current, Packs per day?
☐ Keloid Scars	☐ Widowed	☐ Frequent	_____	_____
☐ Sickle Cell Disease	☐ Live Alone			
☐ High Blood Pressure				

List Medications: _____

_____

Allergies: _____

List ALL surgical procedures: _____

Are you under regular care of any other doctors? _____

Whom may we thank for referring you? _____

Important: May we leave medical information on your home answering machine, voice mail or with a family member for appointment reminders, lab results, insurance coverage, etc?

No_____ Yes_____ If no, please list the number we should use: _____

Consent: I certify that the information in this packet is true and correct to the best of my knowledge. I give my permission to the doctor to administer and perform such procedures as may be deemed necessary in the diagnosis and/ or treatment of my feet, ankles and lower legs. I acknowledge receipt of a copy of the Notice of Privacy Practices and agree to its terms. I hereby authorize medical information to be sent to my primary physician as well as for the purpose of processing my insurance claim.

Signature: _____ **Date**: _____

If signing for a minor, please list your relationship to the patient: _____

Office Use:

Vitals: Right Left Any Falls:_____

Height: _____ DP pulse: How Many:_____

Weight: _____ PT pulse: Steady: Yes or No

BP: _____ Swelling: Last Flu Shot: _____

Pulse: _____ Monofilament:

Resp. rate: ____ Vibratory:

Shoe size: _____ Stance:

Doctor's Notes: _____

_____

Patient Initials: _____ Patient Account Number: _____

Patient Financial Policy for Premier Foot & Ankle

Your understanding of our financial policies is an essential element of your care and treatment. If you have any questions, please discuss them with the front office staff or supervisor.

- As our patients, you are responsible for all authorizations/ referrals needed to seek treatment in this office.
- Your insurance policy is a contract between you and your insurance company. As a courtesy, we will file your insurance claim for you if you assign benefits to the doctor. In other words, you agreed to have your insurance company pay the doctor directly. If your insurance company does not pay the practice within a reasonable period, we will have to look to you for payment.
- We have made prior arrangements with certain insurers and other health plans to accept an assignment of benefits. We will bill those plans with which we have an agreement and will only require you to pay the co-pay/ coinsurance/ deductible at the time of service.
- If you have insurance coverage with a plan with which we do not have a prior agreement, **all charges for your care and treatment are due at the time of service.**
- All health plans are not the same and do not cover the same services. **In the event your health plan determines a service to be "not covered," or you do not have an authorization, you will be responsible for the complete charge**.
- We will attempt to verify benefits for some specialized services or referrals; however, you remain responsible for charges to any service rendered. Patients are encouraged to contact their plans for clarification of benefits prior to services rendered.
- You must inform the office of all insurance changes and authorization/ referral requirements. In the event the office is not informed, you will be responsible for any charges denied.
- For most services provided in the hospital, we will bill your health plan. Any balance due is your responsibility.
- There are certain elective surgical procedures for which we require pre-payment. You will be informed if your procedure is one of those. In that event, payment will be due one week prior to the surgery.
- Past due accounts are subject to collection proceedings. All costs incurred including, but not limited to, collection fees, attorney fees and court fees shall be your responsibility in addition to the balance due this office.
- **A $25 fee will be added to your account for any cancellation not received within 24 hours of your appointments.**
- There is a service fee of $25 for all returned checks. Your insurance company does not cover this fee.

Name of Patient/ Responsible Party: _____

Signature: _____ **Date**: _____

Witness Name and Signature: _____ **Date**: _____

Patient Initials: _____ Patient Account Number: _____

ACKNOWLEDGMENT 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 chose) and understood the Notice.

Patient Name (print):_____

Parent or Authorized Representative (if applicable)

_____

Signature: _____

Patient Initials: _____

Patient Account Number: _____