



OFFICE USE ONLY

Dr. Schoenhaus     Med Info  
 Dr. Gold             Notes  
 Dr. Kane              Chart

## WELCOME TO OUR OFFICE

**Patient Name:** \_\_\_\_\_ **DOB:** \_\_\_\_\_ **SSN:** \_\_\_\_\_

**Address:** \_\_\_\_\_ **City:** \_\_\_\_\_ **State:** \_\_\_\_\_ **Zip:** \_\_\_\_\_

**Alternate Address:** \_\_\_\_\_ **City:** \_\_\_\_\_ **State:** \_\_\_\_\_ **Zip:** \_\_\_\_\_

**Home Phone:** \_\_\_\_\_ **Cell:** \_\_\_\_\_ **E-mail:** \_\_\_\_\_

**Occupation:** \_\_\_\_\_ **Employer:** \_\_\_\_\_

**How did you hear about us?** \_\_\_\_\_

*\*This information is required for Electronic Health Records which is mandated by the Government to comply with Meaningful Use*

**Ethnicity:**  Caucasian  African American  Hispanic  Asian  Pacific Islander  American Indian  Other Race  Declined

**Language:**  English  Spanish  Other \_\_\_\_\_

**INSURANCE INFORMATION:**

**Primary Insurance:** \_\_\_\_\_ **Secondary Insurance:** \_\_\_\_\_

**PRIMARY CARE PHYSICIAN:**

**Dr.** \_\_\_\_\_ **City:** \_\_\_\_\_ **State:** \_\_\_\_\_

**Phone:** \_\_\_\_\_ **Date of Last Office Visit:** \_\_\_\_\_ **Hgb A1C (Diabetics):** \_\_\_\_\_

**EMERGENCY CONTACT:**

**Name:** \_\_\_\_\_

**Relationship:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

**RELEASE OF INFORMATION:**

**Name:** \_\_\_\_\_

**Relationship:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

**Do you have a Living Will/Advanced Directive?** \_\_\_\_\_

**Signature of Patient/Guardian:** \_\_\_\_\_ **Date:** \_\_\_\_\_



## MEDICAL INFORMATION

Patient Name: \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_ Shoe Size \_\_\_\_\_

What are you being seen for today? \_\_\_\_\_

Was this caused by and injury? \_\_\_\_\_ If yes, Date of Injury \_\_\_\_\_ Any previous treatments? \_\_\_\_\_

### MEDICATIONS AND DOSES/See attached

\_\_\_\_\_  
\_\_\_\_\_

Have you had any of the following vaccines? \_\_\_ Flu Shot \_\_\_ Pneumovax \_\_\_ Shingles \_\_\_ COVID

### PHARMACY

Name: \_\_\_\_\_ Location: \_\_\_\_\_ Phone: \_\_\_\_\_

### ALLERGIES

\_\_\_ Aspirin \_\_\_ Latex \_\_\_ Dyes \_\_\_ Penicillin \_\_\_ Lidocaine \_\_\_ Codeine \_\_\_ Shell Fish \_\_\_ Sulfa \_\_\_ **NONE**

### HAVE YOU HAD ANY OF THE FOLLOWING CONDITIONS

___ Arthritis	___ Vascular Disease	___ Kidney Disease	___ HIV	___ Depression
___ Osteoporosis	___ Hepatitis	___ Neuropathy	___ IBS	___ <b>NO PAST ILLNESSES</b>
___ Bleeding Disorders	___ Heart Disease	___ Hypertension	___ Reflux Disease	
___ Blood Clots	___ High Cholesterol	___ Epilepsy	___ Stomach Ulcers	
___ Stroke	___ Diabetes	___ Lung Disease	___ Thyroid Disease	

Other: \_\_\_\_\_

Do you have bulging or varicose veins?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do your leg(s) ever feel heavy, tired, or achy- especially at the end of the day?_	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do your legs swell at the end of the day?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you ever had a thrombus or blood clot in your leg(s)?_	<input type="checkbox"/> Yes <input type="checkbox"/> No
Is the kin below your knees darker in color or hard?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you ever had an ulcer or open sore on your lower leg?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you ever worn or been advised to wear compression stockings?	<input type="checkbox"/> Yes <input type="checkbox"/> No

### Past Surgical History

\_\_\_ Heart Surgery \_\_\_ Spine \_\_\_ Cancer \_\_\_ Vein Surgery \_\_\_ **NO PAST SURGERIES**  
\_\_\_ Pacemaker \_\_\_ Joint Replacement \_\_\_ Gynecological \_\_\_ Vascular Surgery

Have you had any procedures done on your feet or legs? Yes \_\_\_ No \_\_\_

If yes, please explain \_\_\_\_\_

### Current Information

Pregnant? _____ Yes ___ No	Do you smoke cigarettes/cigars? ___ Yes ___ No
Do you have a history of drug use _____ Yes ___ No	If yes, how many per day _____
Do you drink alcohol? _____ Yes ___ No	Are you a former smoker _____ Yes ___ No
How many per day? _____	



**FOOT, ANKLE  
& LEG VEIN  
CENTER**

*Walk with Comfort and Look Great Doing It!*

**Family Medical History**

Mother:    \_\_\_ Alive    \_\_\_ Deceased    Medical Illnesses: \_\_\_\_\_  
 Father:    \_\_\_ Alive    \_\_\_ Deceased    Medical Illnesses: \_\_\_\_\_  
 Sister:    \_\_\_ Alive    \_\_\_ Deceased    Medical Illnesses: \_\_\_\_\_  
 Brother:   \_\_\_ Alive    \_\_\_ Deceased    Medical Illnesses: \_\_\_\_\_

I authorize Foot, Ankle & Leg Vein Center and/or any healthcare professional to perform a physical examination, diagnostic testing, procedures and to prescribe a therapeutic regimen. I also authorize Foot, Ankle & Leg Vein Center and the staff to release and/or collect information including diagnosis acquired in the course of my exam to/from any healthcare facilities, physicians or insurance carriers.

**Patient/Guardian Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_



## FINANCIAL POLICY

PLEASE read & understand Foot Ankle & Leg Vein Center's financial policy that is as follows:

**I understand that it is ultimately my responsibility to understand my insurance contract and what I will be responsible for financially.**

I understand and agree that **I am responsible** for any co-pay, co-insurance and deductible amounts that are part of my insurance contract.

'We have prepared this to help you understand the complexities of medical insurance, realizing how confusing it can be. To begin, we would like to highlight a misconception; medical insurance was not designed to pay for all medical care. Most contracts have limits and/or various degrees of payment.

All levels of payment by insurance companies, including allowed fees, usual and customary (UCR), are governed by the premiums paid. They have nothing to do with the actual charges by a physician. Our fees are based upon a combination of our cost, our time, and our constant dedication to supplying our patients with the highest quality medical care. The treatment recommended by our office is never based on what your insurance company will pay; your treatment should not be governed by your insurance contract.'

I hereby **accept responsibility** to pay for any service(s) provided to me that **is not covered by my insurance**, along with (DME products: ace bandages, shower bags, stockings, orthotics, walking boots, post-op shoe, creams, lotions, etc.). All products are non refundable. **Payments are due at time of service.** If the balance or payment arrangements are not paid within the first 30 days of the statement, then the account will be sent to a collection agency. At which time the current balance will incur an additional 35 % collection fee.

***Our office has a policy for any Self Pay Treatments with the Doctor and our Medical Pedicure Program that are "canceled "in less than a 24 hours from your scheduled appointment time or you should "No Show" there will be a \$50.00 fee.*** The reason for this is to encourage our patients to take their appointments as seriously as we do. That time is reserved for you and if you do not keep your appointment then other patients who need an appointment the schedule permits are being obligated to wait longer than necessary.

\*Signing below means you have read and agree to all terms of this policy.

I hereby authorize payment of medical benefits billed to my insurance to Foot, Ankle & Leg Vein Center.

Print Patient Name: \_\_\_\_\_

Patient Signature : \_\_\_\_\_ Date : \_\_\_\_\_



## CONSENT TO THE USE AND DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT, PAYMENT, OR HEALTHCARE OPERATIONS

I understand that as part of my healthcare, this practice originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plan for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment
- A means of communication among the many health professionals who contribute to my care
- A source of information for applying my diagnosis and surgical information to my bill
- A means by which a third-party payer can verify that services billed were actually provided, and
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand and have been provided with a *Notice of Privacy Practices* that provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. I understand that the organization reserves the right to change their notice and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Privacy Practices*. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that the organization is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon.

Patient Name: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

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### OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on this *Notice of Privacy Practices Acknowledgement*, but was unable to do so as documented below:

Date:	Initials:	Reason:
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