METRO TULSA
Foot & Ankle
SPECIALISTS

PERSONAL INFORMATION NEEDED TO FILE WITH YOUR INSURANCE COMPANY:

Patient Name: _____ _____ ____ _____
(Last) (First) (M.) (Nickname)

Date of Birth: _____ Age: _____ Sex: M/F SS# _____

Address: _____ City/State/Zip: _____

Best Contact Number: _____ Cell Phone: _____

Employer_____ Work Number:_____

Emergency Contact: _____ Phone Number: _____

Race:
[ ] Asian [ ] African American/Black [ ] Native Hawaiian/Pacific Islander [ ] American Indian or Alaska Native [ ] White/Other

Ethnicity: [ ] Hispanic/Latino [ ] Not Hispanic/Latino Date of Last Tetanus (if known): _____

Primary Care Doctor: _____ Date of Last Exam: _____

Pharmacy Preference: _____ City/State: _____

Responsible Party (person signing paperwork): [ ] Self – Skip to Insurance [ ] Spouse [ ] Parent/Legal Guardian
[ ] Other: _____

Name: _____ _____ _____ Relationship: _____
(Last) (First) (M.)

Date of Birth: _____ Age: _____ Sex: M/F SS# _____

Address: _____ City/State/Zip: _____

Best Contact Number: _____ Work Phone: _____

Insurance Information	**Primary**	**Secondary**
Insurance Name	_____	_____
Policy Number	_____	_____
Policy Holder Name	_____	_____
Policy Holder Date of Birth	_____	_____

Please read and sign the following authorization and assignment information:

I hereby authorize ***Justin T. Albright, DPM, Jeremy M. Mason, DPM, P. Shawn Hatfield, DPM, Jill Jackson-Smith, DPM, Steven B. Smith, DPM, Nathan J. Lashley, DPM, Timothy J. Siegfried, DPM, Maureen L Crotty, DPM, David A Francis, DPM, Kevin Quang, DPM and/or Holly B. Lashley, DPT*** to furnish information to insurance carriers concerning my illness; I hereby assign to the doctor (s) all payments for medical services rendered to myself or my dependents. I understand that I am responsible for any amount not covered by insurance or Medicare. I hereby give permission to the above-mentioned doctors to administer treatment and perform such procedures as may be deemed medically necessary in the diagnosis and/or treatment of my foot or ankle condition. I also authorize the use of clinical photography to document my condition and understand that this may be used in lectures, scientific papers, and clinical training. All professional services rendered are charged to the patient. Necessary forms will be completed to expedite insurance claims. The patient is responsible for all fees, regardless of insurance coverage. It is customary to pay for services rendered unless arrangements are made in advance**. I AUTHORIZE THE USE OF MY SIGNATURE ON THIS FORM FOR ALL MY INSURANCE SUBMISSIONS. TO MY KNOWLEDGE, THE ABOVE INFORMATION IS CORRECT. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES MADE TO THE ABOVE-NAMED PATIENT. I understand that a $35.00 cancellation fee may be charged for missed or cancelled appointments unless a forty-eight (48) hour notice is given.** I have been informed that my physician has a vested interest in Memorial Surgery Center, and Tulsa Spine and Specialty Hospital.

_____ _____
PATIENT OR PATIENT REPRESENTATIVE SIGNATURE DATE

Name:_____
Chart Number:_____

If not referred, how did you find out about our practice? _____

What is your primary foot and/or ankle problem? _____
_____
_____
_____
_____
_____
_____

What is your goal for coming in to this appointment?
_____
_____
_____
_____
_____

Which foot/ankle is associated with the problem (Right, Left or Both)? _____

Date Symptoms began: _____ ***Are they symptoms worsening over time***? _____

Rate your current pain level: 0 (No Pain) – 10 (Worst Pain Ever): _____

Have you been treated for this condition in the past? (If yes, by whom)
_____
_____
_____
_____
_____

Please describe all previous foot and ankle treatments (i.e. over the counter products, injections, surgeries, etc):_____
_____
_____
_____
_____

Patient Medical History

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

Any Childhood Illnesses: **(measles, mumps, chicken pox, polio, etc)**

_____

_____

Reviewed by Doctor: _____

Name:_____
Chart Number:_____

Have you been treated for any of the following illnesses? (Check all that apply)

___Alzheimer's Disease
___Anemia
___Arthritis - Osteo
___Arthritis - Rheumatoid
___Asthma
___Atrial Fibrillation
___Avascular Necrosis
___Berger's Disease
___Blood Disease
___Bronchitis
___Cancer
*Type:*_____
___Cerebral Palsy
___Congestive Heart Failure
___Crohn's Disease
___Clotting Disorder
___Dementia
___Depression
___Diabetes
*Controlled By*_____
Type 1 or Type 2
How Long: _____
Most Recent A1c: _____
___Lupus
___Eczema
___Emphysema
___Epilepsy
___Fibromyalgia
___GERD
___Heart Attack
___Heart Disease
___Hepatitis
Type _____
___High Blood Pressure
___High Cholesterol
___History of Joint Replacement
___HIV
___Hyperthyroidsim
___Hypothyroidism
___IBS
___Keloids (Big Scars)
___Kidney Disease
___Liver Disease
___Mitral Valve Prolapse
___Multiple Sclerosis
___Neurological Disorder
___Neuropathy
___Osteoporosis
___Pacemaker
___Parkinson's Disease
___Peripheral Vascular Disease
___Poor Circulation
___Prolonged Bleeding
___Psoriasis
___Pulmonary Embolism
___Raynaud's Syndrome
___Restless Leg Syndrome
___Rheumatic Fever
___Scleroderma
___Seizures
___Shingles
___Sickle Cell Anemia
___Skin Ulcers (Foot and Ankle)
___Spinal Stenosis
___Stomach Ulcers
___TB
___Vertigo
___Warts

___Other: _____
___Other:_____
___Other:_____
___Other:_____

***CURRENT MEDICATION LIST*:**

_____
_____
_____
_____
_____
_____
_____
_____

***ALLERGIES*:**

_____
_____
_____
_____
_____
_____
_____
_____

***Women Only*:**

Are you pregnant or think you may be pregnant? _____
Are you nursing? _____
Are you taking oral contraceptives? _____
Have you been through menopause? _____
Number of Pregnancies? _____ *Births?* _____

Please note: We take X-Rays in the office
Some medications (i.e. antibiotics)
may change the effectiveness of some birth control medications.

Reviewed by Doctor: _____

Name:_____
Chart Number:_____

Previous Hospitalizations and/or Surgeries (Please note dates and any complications?)

_____ _____
_____ _____
_____ _____

Social History

Marital Status: __ Married __Single __Divorced __ Widowed I live: __ Alone __With Someone/Others

Children: __ No __Yes Number of Children/Ages: _____

Alcohol Use: __ No __ Yes (How many drinks per week? _____)

Tobacco Use: ___Current (Packs per day____) ___Never Smoked ___Former Smoker (when did you quit smoking _____)

Current Occupation: _____ Number of Hours on Feet per Day: _____

___Sit ___Stand ___Sit/Stand

Family History

	Living/Age	Deceased/Age	Hereditary Illness/Cause of Death
Mother			
Father			
Sibling			
Sibling			
Sibling			
Child			
Child			
Child			

Review of Systems- Check all that apply

(Please note if you have experienced any of the following in the past six (6) months)

___Acid Reflux
___Back Pain
___Blackouts
___Calf Cramps
___Chest Pain
___Chills
___Cold Fingers/Toes
___Cold Intolerance
___Diarrhea
___Easy Bruising
___Fever
___Fluttering Heart
___Foot Cramp
___Foot Pain w/ First Step in AM
___Frequent Falling
___Frequent Urination
___ Heat Intolerance
___Instability on Feet
___Itching
___Leg Swelling
___Light or Dark Stools
___Morning Stiffness
___Nausea
___Nervousness
___Numbness in Feet
___Radiating Leg Pain
___Recent Weight Loss
___Shortness of Breath
___Skin Rash
___Stomach Problems
___Other: _____

Reviewed by Doctor: _____

Patient Name_____
Chart Number: _____

CONTACT INFORMATION SHEET

Patient Name: _____ Date of Birth: _____

Best Contact Telephone Number: _____

Cell Phone Number (if not listed above): _____

Email Address: _____

Please initial each box as applicable:

PRIVACY POLICIES

_____ I acknowledge that I was provided a copy of the Notice of Privacy Practices. I have read (or had the opportunity to read if I chose) and understand the notice. This notice is also published at www.tulsafoot.com for future reference.

_____ I (Patient/Patient's Representative) give permission to Metro Tulsa Foot and Ankle Specialists to discuss my medical and/or billing information to the following person/persons only:

_____

_____

Metro Tulsa Foot and Ankle Specialists WILL NOT disclose medical or financial information to any party not listed on this form without written consent from the patient or patient's representative.

COMMUNICATION PREFERENCES

_____ **I would like an automated reminder of any upcoming appointment.**
My contact preference is:

_____ Phone Call

_____ Text

_____ I do not want an appointment reminder

Metro Tulsa Foot and Ankle Specialists reserve the right to charge a $35.00 No-Show Fee for missed appointments without a forty-eight (48) notice.

_____ _____ _____
Patient/Authorized Representative Signature Relationship Date

METRO TULSA
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Financial Policy

Thank you for choosing Metro Tulsa Foot and Ankle Specialists, PLLC for your Podiatry needs. Our primary goal is rendering the best care available; therefore, if you have any questions regarding this Financial Policy, please contact our Billing Department at 918-494-2902 option 4.

For your convenience, we accept **Cash, Check, Master Card, Visa, and Discover.** Payments are also accepted on our website – www.tulsafoot.com.

Self Pay Patients: Payment is due at the time service. We do offer a 20% discount if the balance is paid in full.

Insurance Requirement: Patients must present a copy of their insurance card at the time of service. Failure to present proper insurance identification will result in self-pay status.
We do not accept Third Party Insurance Claims.

Returned checks will be handled through Payliance via electronic check. There is a return check fee of $35.00.

The patient and/or responsible party must provide their social security number for collection purposes. This information is considered PHI, protected by HIPAA Standards. This information is not used or released for any other purpose.

Customized Items, Orthotics, and/or Durable Medical Supplies are **non-refundable.**

In effort to help prevent Identity Theft, we are following the AMA-Suggested Guidelines for Red Flag Rules (as required by the FTC). We now require photo identification for all patients, in addition to, their current insurance card. A photograph may be taken at the time of service and stored in your chart.

Delinquent accounts will be turned to the outside Collection Agency of our choice. Accounts are considered delinquent if unpaid after 60 days. In the event your account is turned to collections, you will be required to pay this outstanding balance in full prior to initiating treatment with any physician within the practice. Delinquent accounts are subject to dismissal.

All Billing Inquiries should be directed to (918) 494-2902 Monday-Thursday from 7:30am-4:30pm.

I have read and understand the financial policy of Metro Tulsa Foot and Ankle Specialists, PLLC

_____ _____

Patient Signature Date