Foot and Ankle Clinics, P.A.

Jeff Pellersels, DPM **Russell J. Hill, DPM**

Office Fax: 651-457-3115

563 Bielenberg Drive, #150
Woodbury, MN 55125
TEL: 651-730-7796

1545 Livingston Ave., #100
West St. Paul, MN 55118
TEL: 651-457-4665

6545 France Ave. S. #565
Edina, MN 55435
TEL: 952-934-9360

PATIENT INFORMATION *Please fill out completely or mark n/a if does not apply.*

NAME_____ Date of Birth_____

Address_____ City_____ State_____ Zip_____

Cell Phone_____ Home Phone_____ Preferred: Cell/Home

Email_____

Sex: ☐ Male ☐ Female ☐ Prefer Not to Answer ☐ Non-binary

Height_____ Weight_____ Shoe Size_____

Ethnicity American Indian/Alaskan Native Asian/Pacific Islander Black/African American
Hispanic/Latino Caucasian/White Other_____

Employed: Yes No Name_____ Position_____

Emergency Contact_____

Relationship_____ Phone Number_____

PRIMARY CARE DOCTOR_____ Date Last Seen_____

CLINIC NAME_____LOCATION_____

REFERRING DOCTOR_____LOCATION_____

PHARMACY INFORMATION

Name of Pharmacy_____LOCATION_____

INSURANCE *Please give all cards to the receptionist to copy for your chart.*

Primary Insurance Company Name_____

Policy Holder Name_____ Date of Birth_____

Secondary Insurance Company Name_____

SOCIAL HISTORY *(Please check all that apply)*

Cigarettes	☐ Current	☐ Former	☐ Never Smoked
E-Cigarette	☐ Current	☐ Former	☐ Never Smoked
Alcohol Use	☐ None	☐ Rarely	☐ Moderate/Daily
Recreational Drugs	☐ Current	☐ Former	☐ Never Used
Marijuana Use	☐ Current	☐ Former	☐ Never Used

PAST MEDICAL HISTORY *(Have you been treated for any of these conditions, please check all the apply)*

☐ Anemia	☐ Diabetes: Type I or II	☐ Liver Problems	☐ Vascular Disease
☐ Anxiety	☐ Epilepsy/Seizures	☐ Neuropathy	☐ None
☐ Arthritis	☐ Gout	☐ Osteoporosis	
☐ Asthma	☐ Heart Disease	☐ Phlebitis	
☐ Auto Immune Disease	☐ Hepatitis B or C	☐ Poor Circulation	
☐ Back Problems	☐ High Blood Pressure	☐ Polio	☐ Other: _____
☐ Cancer:_____	☐ High Cholesterol	☐ Polio	
☐ Depression	☐ HIV/AIDS	☐ Thyroid Problems	

PAST PODIATRIC HISTORY *(Please check all that apply)*

☐ Amputation	☐ Calluses	☐ Hammertoes	☐ Leg/Foot Cramps
☐ Athlete's Foot	☐ Flat Feet	☐ Heel/Arch Pain	☐ Leg/Foot Ulcer
☐ Bunions	☐ Foot Numbness	☐ High Arches	☐ Neuroma
☐ Corns	☐ Fungal Nails	☐ Ingrown Toenails	☐ Warts

Past Foot Surgeries_____

ALLERGIES *(Please check all that apply)*

☐ Adhesive/Tape	☐ Codeine	☐ Iodine	☐ Sulfa
☐ Anesthetics	☐ Cortisone	☐ Latex	☐ Tylenol
☐ Aspirin/Aleve/Advil	☐ Erythromycin	☐ Penicillin	☐ Other: _____
			☐ None

ASSIGNMENT OF BENEFITS:

I authorize all medical benefits to be paid directly to Foot and Ankle Clinic P.A. I authorize Foot and Ankle Clinics P.A. to release to my insurance company, health plan, HMO, no fault or worker's compensation carrier, my complete health records needed to determine benefits for services provided. I am responsible for all services paid for by my insurance company. Should I become delinquent, I agree to pay collection costs, attorney fees, interest or any costs associated with my account being placed for collection and/or attorney litigation. I authorize Foot and Ankle Clinic P.A. to release my information to my primary care physician or referring physician.

Signaure_____ Date_____

MEDICARE PATIENTS: I request Medicare payments to be made directly to Foot and Ankle Clinic P.A. for any services furnished to me. I authorize the release of information about my care to HCFA and its' agents.

Signature_____ Date_____

NOTICE OF PRIVACY PRACTICES

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is a federal program that requires all medical records and other individually identifiable health information used or disclosed by Foot and Ankle Clinic, P.A. to be kept confidential.

As required by HIPAA, we have summarized how we intend to maintain privacy of your personal health information (PHI).

We may use and disclose your medical records for the following purposes:

- Treatment may require that your information be disclosed to other health professionals who are involved in your care, such as specialists to whom you have been referred.
- Payment includes such activities as submitting claims to your insurance company for reimbursement, confirming eligibility or utilization review.
- Healthcare operations include the business aspects of running our practice, such as internal quality review, auditing functions or cost management analysis.

We may also contact you by phone, voicemail, or mail/email to provide you with appointment reminders or information regarding your treatment.

Any other use and disclosure of your health information will be made only with your written authorization unless already authorized by law.

You have the following rights with respect to your protected health information (PHI):

- The right to reasonable requests to receive confidential communication of your PHI
- The right to inspect and copy your PHI
- The right to receive an accounting of disclosures of your PHI
- The right to request an amendment of your PHI

This NOTICE OF PRIVACY PRACTICES is effective 4.1.2003 and will remain in effect unless changed by law. We are required to abide by its' terms. If you feel your privacy protections have been violated, you have the right to file a formal, written complaint and forward it to the attention of the Privacy Officer at any of our clinic locations.

I HAVE READ AND UNDERSTAND THE NOTICE OF PRIVACY PRACTICES OF FOOT AND ANKLE CLINICS, P.A.

Signature_____ Date_____

Printed name_____ Date of Birth _____