Acacia
FOOT & ANKLE SURGEONS

## Personal information

**Last Name:** _____ **First Name:** _____ **Middle:**_____

**Date of Birth:** _____ **Sex:** ☐Male ☐Female ☐Other_____

**Social Security Number:** _____ **E-mail:** _____

by providing my email I consent to receive relevant emails from Acacia Foot & Ankle Surgeons

**Reason for Your Visit Today:** _____

Your Primary Care Physician: _____ Tel _____

Your Pharmacy Name & Address: _____

Marital Status: ☐Single ☐Married ☐Other _____

**Home Address:** _____

**City:** _____ **State:** ____ **Zip Code** _____ **Phone Number:** _____

By providing my phone number I consent to receive relevant text messages including appointment information, personal intercommunications, and occasional marketing material.

To **opt out** of receiving text messages please check this box ☐

## Emergency contact

Name: _____ Relationship to Patient: _____

Tel Number: _____

Address: _____ City: _____ State: _____ Zip Code _____

**How Did You Hear About Us?**

☐Internet/Google ☐Friend/Family ☐Doctor Referral ☐Other _____

**Primary Insurance Name**: _____

**Secondary Insurance Name** (if applicable) _____

**Supplemental Insurance Name** (If applicable) _____

***** Please provide us with a copy of your insurance card(s).**

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**Patient's Name:** _____ **Date of Birth:** _____

## Past Medical History

**Please check all that apply:** ( ☐ I do not have any medical issues)

☐Anemia
☐Angina
☐Alzheimer's Disease
☐Anxiety
☐Arrhythmia
☐Asthma
☐Arthritis (Osteoarthritis)
☐Arthritis (Rheumatoid)
☐Blood Clotting Disorder (Specify_____)
☐Bronchitis
☐COPD
☐Cancer (Specify _____)
☐Deep Vein Thrombosis (DVT)
☐Dementia
☐Depression
☐Diabetes
☐Emphysema
☐Fibromyalgia
☐Gout
☐Hyperthyroidism
☐Hypothyroidism
☐High Cholesterol
☐High Blood Pressure
☐Heart Attack
☐Kidney Disease (Stage _____)
☐Liver Disease (Specify_____)
☐Neuropathy
☐Osteopenia
☐Osteoporosis
☐Pulmonary Embolism (PE)
☐Restless Leg Syndrome
☐Sleep Apnea
☐Seizures
☐Spinal Disorder
☐Stroke
☐Tachycardia
☐TIA

**Infectious Disease:** ☐ Tuberculosis ☐Hepatitis A ☐Hepatitis B ☐Hepatitis C ☐HIV/AIDS ☐MRSA

**Other:** _____

**Allergies:** ☐Penicillin ☐Sulfa ☐Iodine ☐Tape/Adhesives ☐Latex
☐Other _____

**Medication List** (Please provide a separate sheet, if list is longer than this page)

| Medication Name | Dosage | Times/Day |
|---|---|---|
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## Past Surgeries

_____

_____

## Family History

Maternal: _____

Paternal: _____

## Social History

Smoking (Nicotine): ☐ Yes ☐ No ☐ Former Smoker (Date of Cessation _____)

Vaping: ☐ Yes ☐ No ☐ Former Vapor (Date of Cessation _____)

Alcohol Consumption: ☐ Yes ☐ No ☐ Former Alcoholic (Date of Cessation _____)

Recreation Drug Use: ☐ Yes ☐ No ☐ Former User (Date of Cessation _____) Type: _____

**Consent to Release Information (**Choose one option)

☐ **I do not consent to release of any of my information to anyone.**

**OR**

☐ **I consent to release of my information to family and friend of my choosing, for purpose of treatment, payment, and healthcare operations. Acacia Foot and Ankle Surgeons, including the providers and staff members, has my permission to release my confidential health information to the following individuals who are involved in my care:**

Individual Name: _____ Relationship to Patient: _____

Individual Name: _____Relationship to Patient: _____

I understand that I have the right to revoke this permission, in writing, at any time and that disclosures made in good faith may have already occurred and that the withdrawal of permission cannot be applied retro-actively.

Signature _____ Today's Date _____

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## Notice of Acknowledgment

Office hours are by appointments only. I understand that failure to notify our office of cancellation within 24 hours may result in a $40 charge prior to scheduling your next appointment.

I understand that co-payments and/or co-insurance amounts are due and payable at the time of service. The final amount that your insurance carrier determines, is your responsibility and payable within 30 days of notification by our billing department.

I understand that the office will submit insurance claims following each visit and treatment. I confirm that prior to each of my office visits and treatments, I have established eligibility with my insurance company. I understand that I am responsible to notify the office of any changes with my insurance prior to any subsequent visits.

I understand that if I do not have an active insurance policy at the time of the service, I am fully responsible for the amount for the service rendered payable within 30 days of notice.

Signature of patient or guardian _____ Date _____

Relationship to patient if signed by representative _____