EMERALD COAST
FOOT AND ANKLE CENTER

LAST_____FIRST_____MIDDLE_____

D.O.B_____AGE_____SEX_____MARITAL STATUS____ SS#_____

HOME PHONE_____CELL_____E-MAIL_____

ADDRESS_____CITY_____STATE_____ZIP_____

MAILING ( ) CHECK BOX IF SAME AS HOME

ADDRESS_____CITY_____STATE_____ZIP_____

NEXT OF KIN OR EMERGENCY/ALTERNATE CONTACT: Name_____Cell_____E-mail_____

EMPLOYER_____LOCATION_____PHONE_____

PRIMARY CARE DOCTOR_____PHONE_____LAST VISIT_____

SPOUSE/
GUARDIAN_____ADDRESS_____CITY_____

STATE_____ZIP_____PHONE_____SS#_____(SPOUSE)

SPOUSE EMPLOYER_____ADDRESS_____PHONE_____

INSURANCE INFORMATION

INFORMATION OF PERSON NAMED ON THE INSURANCE CARD AND THEIR RELATIONSHIP TO PATIENT

NAME_____RELATIONSHIP_____PHONE_____

ADDRESS_____SS#_____BIRTHDAY_____

PERSON RESPONISBLE FOR BILL (MUST BE COMPLETED)
( )CHECK IF SAME AS PATIENT

NAME_____SS#_____BIRTHDAY_____

ADDRESS_____CITY_____STATE_____

PLEASE PROVIDE THE RECEPIONIST WITH THE FOLLOWING DOCUMENTS FOR COPYING:

PRIMARY INSURANCE CARD **SECONDARY INSURANCE CARD** **DRIVER LICENSE or PHOTO ID**

SIGNATURE_____DATE_____

info@ecfootankle.com
P: (850) 660-7778
F: (850) 203-4093

EMERALD COAST
FOOT AND ANKLE CENTER

Please Describe Your Current Foot Problem

_____

_____

_____

_____

Please Check All That Apply

Cardiovascular:
- ○ Ankle swelling
- ○ Calf cramping
- ○ Change in color/temp extremity
- ○ Chest pain or tightness
- ○ Shortness of breath

Endocrine:
- ○ Cuts take longer to heal
- ○ Excessive urination
- ○ High blood sugar
- ○ Low blood sugar
- ○ Unusual Fatigue

Eye/ENT:
- ○ Difficulty swallowing
- ○ Hearing loss
- ○ Legally blind
- ○ Retina disease
- ○ Sinus infection/congestion

Immuno/Hemo:
- ○ Bleeding tendencies
- ○ Clotting difficulties
- ○ Environmental allergies
- ○ Gouty attacks
- ○ Viral infections

Gastro:
- ○ Diarrhea
- ○ Liver disease
- ○ Nausea
- ○ Reflux
- ○ Vomiting

Urinary:
- ○ Blood in urine
- ○ Dysuria/Nocturia
- ○ Frequent urination
- ○ Weak bladder
- ○ Weak kidney

Integument:
- ○ Blisters
- ○ Dry/scaly skin
- ○ Ingrown nail
- ○ Itching
- ○ Foot ulcers
- ○ Slow-healing

Lymph:
- ○ Enlarged node
- ○ Leg swelling
- ○ Cancer

Musculoskeletal:
- ○ Back pain
- ○ Decreased Rom
- ○ Heel pain
- ○ Joint pain
- ○ Morning stiffness
- ○ Weakness

Neurological:
- ○ Burning tingling
- ○ Hypersensitivity
- ○ Numbness
- ○ Paralysis
- ○ Tremors
- ○ Vertigo

Psychiatric:
- ○ Anxiety
- ○ Depression
- ○ Memory loss
- ○ Panic attacks

Respiratory:
- ○ Asthma
- ○ Breathing difficulty
- ○ Cough
- ○ Shortness breath
- ○ Smoker

Surgery/Hospitalizations:

_____

_____

_____

_____

_____

Medical History:
Medical Problems

_____

_____

_____

_____

_____

Medications:
Prescription and OTC

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Your Pharmacy: _____

Allergies

Penicillin	Sulfa	Aspirin
Codeine	Iodine	Shellfish
Tape	Latex	IVP Dye

No Known Drug Allergies (NKDA)

Other: _____

Family Health History

_____

_____

_____

_____

Social History:

Tobacco: **Yes** ____Pk/day ____Yrs. **No**

Alcohol: **Yes** #drinks per day:_____ **No**

Illicit Drug Use: **Yes** **No**

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CONSENT/AUTHORIZATION FORM/RELEASE OF INFORMATION

CONSENT FOR TREATMENT: I AUTHORIZE *DR. CARL SPEER, DPM* TO PERFORM THE TREATMENT/PROCEDURE(S) EXPLAINED TO ME. I HAVE BEEN INFORMED OF THE REASONS FOR THE TREATMENT/PROCEDURE(S), ALONG WITH THE EXPECTED BENEFITS, RISKS, POSSIBLE ALTERNATIVE METHODS OF TREATMENT, AND POSSIBLE CONSEQUENCES. INVOLVED. Initials: _____

THE TREATMENT/PROCEDURE(S) WERE EXPLAINED TO ME IN DETAIL AND ALL MY QUESTIONS WERE FULLY ANSWERED. UNDERSTANDING THIS, I AUTHORIZE EMERALD COAST FOOT AND ANKLE CENTER, PLLC. TO PERFORM EXAMINATIONS, TREATMENTS, LABORATORY TESTS, AND ADMINISTER MEDICATIONS AS, IN THEIR OPINION, ARE NECESSARY AND SERVE MY BEST INTERESTS.

I ALSO CERTIFY THAT NO GUARANTEE OR ASSURANCE HAS BEEN MADE TO THE RESULTS THAT MAY BE OBTAINED. Initials: _____

RELEASE OF MEDICAL RECORD IN ORDER TO ENSURE PROPER FOLLOW-UP AND CONTINUITY OF CARE, I AGREE THAT A COPY OF MY MEDICAL RECORD MAY BE RELEASED TO MY PHYSICIAN, A DESIGNATED REFERRAL PHYSICIAN, AND/OR THE PROVIDER, IF ANY, WHO REFERRED ME TO THIS FACILITY.

Patient Primary Care Physician: _____ Initials: _____

INSURANCE AUTHORIZATION I REQUEST THAT PAYMENT OF AUTHORIZED BENEFITS BE MADE TO DR. CARL SPEER, DPM ON MY BEHALF, FOR ANY SERVICES PROVIDED TO ME. I AUTHORIZED ANY HOLDER OF MEDICAL AND OTHER INFORMATION ABOUT ME TO RELEASE TO MEDICARE AND ITS AGENTS, ANY INSURANCE COMPANY, ANY OTHER THIRD PARTY PAYER, STATE MEDICAL ASSISTANCE AGENCY, OR ANY OTHER GOVERNMENTAL OR PRIVATE PAYER RESPONSIBLE FOR PAYING SUCH BENEFITS, ANY INFORMATION NEEDED TO DETERMINE THESE BENEFITS FOR RELATED SERVICES. I AGREE TO PAY FOR ALL CHARGES NOT COVERED BY A THIRD-PARTY PAYER, I AUTHORIZED A COPY OF THIS AUTHORIZATION TO BE USED IN PLACE OF THE ORIGINAL. Initials: _____

Patient's Name (Printed): _____

SIGNATURE:_____DATE:_____

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

- As our patient, you are responsible for all authorizations/referrals needed to seek treatment in this office.
- Unless other arrangements have been made in advance by you, or your health insurance carrier, payment for office services are due at the time of service. We will accept VISA, MasterCard, Discover, cash or check.
- 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 the benefits to the doctors. In other words, you agree to have your insurance company pay the doctor directly. If your insurance company does not pay the practice within 60 days, you will receive a bill.
- 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 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.
- There are certain elective surgical procedures for which we require pre-payment. You will be informed in advance if your procedure is one of those. In that event, payment will be due one week prior to the surgery or at the time of your Pre-operative appointment.
- 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 to the office.
- Patients who are 90 days past due on their balance will be sent to collections unless a payment plan has been put into place.
- There is a service fee of $25 for all returned checks. Your insurance company does not cover this fee.
- In fairness to all our patients, we understand that emergencies occur, but repeated no shows or cancellations with less than 24 hours' notice will result in a fee of $25. You might be asked to pay before you are seen by the doctor.
- Patients who come to office fifteen minutes later than scheduled appointment might be asked to reschedule.

Signature of Patient/Responsible Party:_____Date:_____

Printed Name of Patient/Responsible Party: _____ Date:_____

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