St. Mary's Office:
(301) 862-3338
Charlotte Hall Office:
(301) 472-1845
Leonardtown Office:
(301) 997-1500

CAPITAL FOOT & ANKLE CARE CENTRE

Solomon's Office
(410) 326-9700
Prince Frederick Office:
(410) 414-5033
Fax all locations:
(301) 862-3335
foot-ankle-care.com

Dr. Douglas H. Hallgren, DPM • Dr. Robert L. VanFosson, DPM • Dr. David R. Hatch, DPM

PATIENT INFORMATION FORM

(PLEASE PRINT)

LAST NAME_____

FIRST NAME_____ MI_____

ADDRESS_____

CITY_____

STATE_____ ZIP_____

PHONE_____ CELL _____

EMAIL_____

MARITAL STATUS ☐ MARRIED ☐ SINGLE ☐ DIVORCED

☐ PARTNERED ☐ SEPARATED ☐ WIDOWED

SEX ☐ MALE ☐ FEMALE

DATE OF BIRTH_____ AGE_____

PRIMARY LANGUAGE_____

PRIMARY PHYSICIAN_____

PHYSICIAN'S PHONE_____

PHYSICIAN'S ADDRESS_____

CITY, STATE, ZIP _____

PHARMACY_____LOCATION_____

EMERGENCY CONTACT_____

RELATIONSHIP_____PHONE_____

WHO IS RESPONSIBLE FOR PAYMENT_____

RELATIONSHIP_____PHONE_____

ADDRESS_____

CITY, STATE, ZIP_____

DO YOU HAVE A LEGAL GUARDIAN OR POWER OF ATTORNEY?

IF YES, NAME_____

RELATIONSHIP_____PHONE_____

DATE_____

WHO REFERRED YOU TO US_____

INSURANCE INFORMATION

PRIMARY COMPANY NAME_____

POLICY HOLDER_____

DATE OF BIRTH_____RELATIONSHIP_____

ID #_____GROUP #_____

SECONDARY COMPANY NAME_____

POLICY HOLDER_____

DATE OF BIRTH_____RELATIONSHIP_____

ID #_____GROUP #_____

SOCIAL HISTORY

ALCOHOL USE: ☐ NEVER ☐ NO LONGER USE ☐ RARE ☐ DAILY

☐ OCCASIONAL ☐ MODERATE ☐ HISTORY OF ALCOHOL ABUSE

TOBACCO USE: ☐ NEVER ☐ QUIT-HOW LONG AGO?_____

☐ SMOKE_____PACKS/DAY FOR_____YEARS

RECREATIONAL DRUG USE: ☐ NEVER

☐ QUIT-HOW LONG AGO?_____TYPE_____

☐ CURRENT USE-TYPE_____HOW OFTEN_____

EMPLOYER_____

OCCUPATION_____PHONE_____

HOW MUCH ARE YOU ON YOUR FEET AT WORK?

☐ 10% ☐ 25% ☐ 50% ☐ 75% ☐ 100%

EXERCISE ☐ NEVER ☐ RARE ☐ OCCASIONAL ☐ WEEKLY

☐ SEVERAL TIMES A WEEK ☐ DAILY

TYPES OF EXERCISE:_____

PLEASE LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING (INCLUDE PRESCRIPTIONS, OVER-THE-COUNTER MEDS AND HERBAL SUPPLEMENTS):

NAME DOSE HOW OFTEN DO YOU TAKE?

PLEASE LIST ALL PRIOR SURGERIES:

TYPE OF SURGERY DATE

PLEASE LIST ALL PRIOR HOSPITALIZATIONS (OTHER THAN FOR SURGERY):

REASON FOR HOSPITALIZATION DATE

FAMILY HISTORY

DO YOU HAVE A FAMILY HISTORY OF:

☐ DIABETES ☐ CANCER ☐ HEART DISEASE ☐ STROKE
☐ HIGH BLOOD PRESSURE ☐ CORONARY ARTERY DISEASE
☐ THYROID DISEASE ☐ RHEUMATOID ARTHRITIS
☐ OTHER _____

YOUR MEDICAL HISTORY

ALLERGIES: ☐ NONE KNOWN ☐ PENICILLIN ☐ SULFA
☐ KEFLEX ☐ CODEINE ☐ MORPHINE ☐ ASPIRIN ☐ TAPE
☐ LATEX ☐ IODINE ☐ OTHER _____

HAVE YOU EVER HAD ANY OF THE FOLLOWING?

ACID REFLUX	Y	N	FIBROMYALGIA	Y	N	NEUROPATHY	Y	N
ANEMIA	Y	N	GOUT	Y	N	OPEN SORES	Y	N
ARTHRITIS	Y	N	HEART ATTACK	Y	N	PNEUMONIA	Y	N
ASTHMA	Y	N	HEART DISEASE/FAILURE	Y	N	POLIO	Y	N
BACK TROUBLE	Y	N	HEPATITIS	Y	N	HEMOPHILIA	Y	N
CELLULITIS	Y	N	HIV+/AIDS	Y	N	SICKLE CELL DISEASE	Y	N
ABNORMAL BLEEDING	Y	N	HIGH BLOOD PRESSURE	Y	N	SKIN DISORDER	Y	N
BLOOD CLOTS	Y	N	KIDNEY DISEASE	Y	N	MUSCULAR DYSTROPHY	Y	N
PSORIASIS	Y	N	LIVER DISEASE	Y	N	STOMACH ULCERS	Y	N
RAYNAUD'S PHENOMENON	Y	N	LOW BLOOD PRESSURE	Y	N	STROKE	Y	N
CANCER	Y	N	MIGRAINE HEADACHES	Y	N	THYROID DISEASE	Y	N
DIABETES	Y	N	CYSTIC FIBROSIS	Y	N	TUBERCULOSIS	Y	N
OSTEOMYELITIS	Y	N	RHUEMATOID ARTHRITIS	Y	N	OSTEOPOROSIS	Y	N
LEUKEMIA	Y	N	GI BLEED	Y	N	EPILEPSY	Y	N

REVIEW OF SYSTEMS: (CHECK THE BOX IF YOU HAVE ANY THESE CURRENTLY)

ALLERGIC/IMMUNOLOGIC: ☐ SEASONAL ALLERGIES ☐ COUGHING ☐ SENSITIVITY TO DUST

RESPIRATORY: ☐ DIFFICULTY BREATHING ☐ CHEST TIGHTNESS ☐ SNORING ☐ SHORTNESS OF BREATH

EARS, EYES, NOSE, THROAT: ☐ DRY EYES ☐ EXCESS TEARING ☐ MACULAR DEGENERATION ☐ ITCHY EYES ☐ GLAUCOMA ☐ HEARING LOSS ☐ BLISTERS IN MOUTH ☐ SORE THROAT ☐ SINUS PROBLEMS

GASTROINTESTINAL: ☐ ABDOMINAL PAIN ☐ BLOOD IN STOOL ☐ HEARTBURN

GENITO-URINARY: ☐ CURRENTLY PREGNANT ☐ ON DIALYSIS ☐ PAINFUL URINATION

CARDIOVASCULAR: ☐ ARM PAIN ☐ CHEST PAIN ☐ COLD HANDS ☐ CALF CRAMPING ☐ HIGH BLOOD PRESSURE ☐ CHEST PRESSURE ☐ COLD FEET

CONSTITUTIONAL SYMPTOMS: ☐ SLEEP PROBLEMS ☐ DIZZINESS ☐ FAINTNESS ☐ FEVER ☐ HEADACHE

MUSCULOSKELETAL: ☐ BACK PAIN ☐ HEEL PAIN ☐ HIP PAIN ☐ JOINT PAIN ☐ JOINT SWELLING ☐ MUSCLE PAIN ☐ NECK PAIN ☐ STIFFNESS

INTEGUMENTARY: ☐ ATHLETES FOOT ☐ CYST ☐ DRY SKIN ☐ DISCOLORATION ☐ LEG SWELLING ☐ LOWER LEG ULCERS

NEUROLOGICAL: ☐ DIZZINESS ☐ CONFUSION ☐ FORGETFULNESS ☐ HEADACHE ☐ MIGRAINES ☐ SEIZURES ☐ TINGLING ☐ TREMORS

HEMATOLOGIC/ LYMPHATIC: ☐ ANKLE/FOOT SWELLING ☐ BRUISE EASILY ☐ CALF PAIN ☐ BLEEDING PROBLEMS

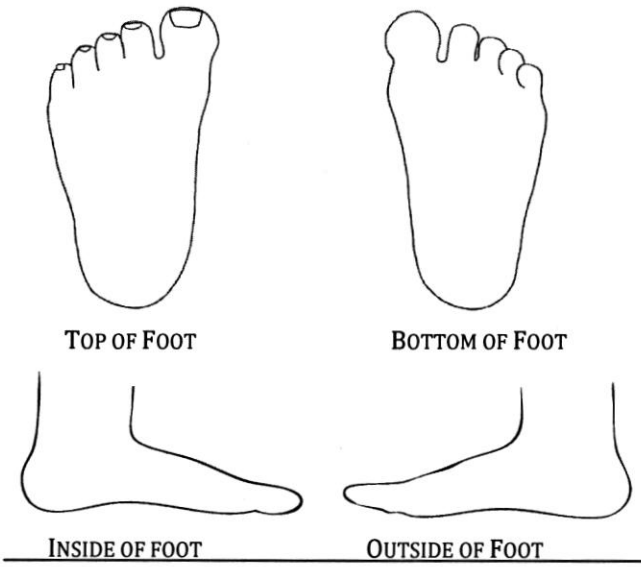
CURRENT HEIGHT: _____ CURRENT WEIGHT: _____ SHOE SIZE: _____ LAST BLOOD PRESSURE READING: _____

CURRENT PROBLEM

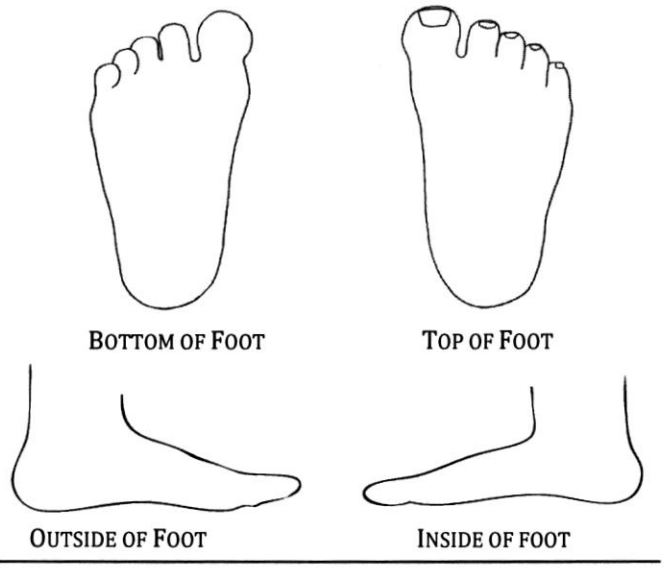
WHAT SPECIFIC PROBLEM BRINGS YOU TO OUR OFFICE TODAY? _____

WHERE IS THE PAIN/PROBLEM LOCATED? PLEASE MARK ON THE PICTURES BELOW.

LEFT FOOT



RIGHT FOOT



HOW LONG AGO DID THIS PROBLEM FIRST START? _____ DAYS / WEEKS / MONTHS / YEARS

DID YOUR PAIN OR PROBLEM: ☐ BEGIN ALL OF A SUDDEN ☐ GRADUALLY DEVELOP OVER TIME

HOW WOULD YOU DESCRIBE YOUR PAIN? ☐ NO PAIN ☐ SHARP ☐ DULL ☐ ACHING ☐ BURNING
☐ RADIATING ☐ ITCHING ☐ STABBING ☐ OTHER _____

HOW WOULD YOU RATE YOUR PAIN ON A SCALE FROM 0 TO 10? (PLEASE CIRCLE)
(NO PAIN) 0 1 2 3 4 5 6 7 8 9 10 *(WORST PAIN POSSIBLE)*

SINCE THE TIME YOUR PAIN OR PROBLEM BEGAN, HAS IT: ☐ STAYED THE SAME ☐ BECOME WORSE ☐ IMPROVED

WHAT MAKES YOUR PAIN OR PROBLEM FEEL WORSE? ☐ WALKING ☐ STANDING ☐ DAILY ACTIVITIES
☐ RESTING ☐ DRESS SHOES ☐ HIGH HEELS ☐ FLAT SHOES ☐ ANY CLOSED TOE SHOE
☐ RUNNING ☐ OTHER _____

WHAT MAKES YOUR PAIN OR PROBLEM FEEL BETTER? _____

WHAT TREATMENTS HAVE YOU HAD FOR THIS PROBLEM? _____

HOW HAS THIS PROBLEM AFFECTED YOUR LIFESTYLE OR ABILITY TO WORK? _____

WAS THIS PROBLEM CAUSED BY AN INJURY? ☐ YES (DESCRIBE) _____ ☐ NO

IF YES, WAS IT A WORK-RELATED INJURY? ☐ YES ☐ NO

TO THE BEST OF MY KNOWLEDGE, I HAVE ANSWERED THE QUESTIONS ON THIS FORM ACCURATELY. I UNDERSTAND THAT PROVIDING INCORRECT INFORMATION CAN BE DANGEROUS TO MY HEALTH. I UNDERSTAND THAT IT IS MY RESPONSIBILITY TO INFORM THE DOCTOR AND OFFICE STAFF OF ANY CHANGES IN MY MEDICAL STATUS.

_____ _____

PRINT NAME OF PATIENT, PARENT OR GUARDIAN | SIGNATURE OF DOCTOR

_____ _____

IF OTHER THAN PATIENT, RELATIONSHIP TO PATIENT | DATE

_____ _____

SIGNATURE | DATE

Do I Need a Test for PAD?

Peripheral Arterial Disease (PAD) is a serious circulatory problem in which the blood vessels that carry blood to your arms, legs, brain, or kidneys, become narrowed or clogged. It affects over 8 million Americans, most over the age of 50. It may result in leg discomfort with walking, poor healing of leg sores/ulcers, difficult to control blood pressure, or symptoms of stroke. People with PAD are at significantly increased risk for stroke and heart attack. Answers to these questions will determine if you are at risk for PAD and if a vascular exam will help us better assess your vascular health status.

Name: _____ Date: _____

Circle "Yes" or "No":

1. Do you have foot, calf, buttock, hip or thigh discomfort (aching, fatigue, tingling, cramping or pain) when you walk which is relieved by rest? Yes No
2. Do you experience any pain at rest in your lower leg(s) or feet? Yes No
3. Do you experience foot or toe pain that often disturbs your sleep? Yes No
4. Are your toes or feet pale, discolored, or bluish? Yes No
5. Do you have skin wounds or ulcers on your feet or toes that are slow to heal (8-12 weeks)? Yes No
6. Has your doctor ever told you that you have diminished or absent pedal (foot) pulses? Yes No
7. Have you suffered a severe injury to the leg(s) or feet? Yes No
8. Do you have an infection of the leg(s) or feet that may be gangrenous (black skin tissue)? Yes No
9. Have you had blockages in your coronary or heart arteries? Yes No

Patient Signature: _____ Date: _____

Physician's Signature: _____ Date: _____

Patient Financial Policy

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 or supervisor.

- 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 doctor. In other words, you agree to have your insurance company pay the doctor directly. If your insurance company does not pay the practice within a reasonable period, we will have to look to you for payment.
- We have made prior arrangements with certain insurers and other health plans to accept an assignment of benefits. We will bill those plans with which we have an agreement and will only require you to pay the co-pay/co-insurance/deductible at the time of service.
- If you have insurance coverage with a plan with which we do not have a prior agreement, we will prepare and send the claim for you on an unassigned basis. This means your insurer will send the payment directly to you. Therefore, all charges for your care and treatment are due at the time of service.
- 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 some specialized 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.
- For most services provided in the hospital, we will bill your health plan. Any balance due is your responsibility.
- 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.
- 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 this office.
- There is a service fee of $25.00 for all returned checks. Your insurance company does not cover this fee.
- There is a $30.00 no show fee for appointments not cancelled prior to the appointment time and $300 for missed surgical appointments.

Signature of Patient/Responsible Party: _____

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

Witness Signature: _____ Date: _____

Printed Name of Witness: _____

ACKNOWLEDGMENT OF RECEIPT

OF

NOTICE OF PRIVACY PRACTICES

I ACKNOWLEDGE THAT I WAS PROVIDED A COPY OF THE NOTICE OF PRIVACY PRACTICES AND THAT I HAVE READ (OR HAD THE OPPORTUNITY TO READ IF I SO CHOSE) AND UNDERSTOOD THE NOTICE.

_____ _____

PATIENT NAME (PLEASE PRINT) DATE

_____

PARENT OR AUTHORIZED REPRESENTATIVE (IF APPLICABLE)

_____

SIGNATURE