Welcome to Foot & Ankle Associates of Maine. We sincerely appreciate you choosing our practice for your foot and ankle health. Enclosed you will find your appointment card indicating the date and time of your appointment. If you are unable to keep this date and/or time, please call us at **207-725-4008** so that we can reschedule your appointment. We will make every effort to accommodate your schedule.

Please be on time for your appointment to avoid being rescheduled.

What to bring with you:

- A completed Patient Information / Insurance Form (enclosed).
- Your insurance card(s).
- Referral information (if available).

If you have not completed these forms prior to your visit, please arrive 15 minutes early to complete the necessary paperwork. This will keep our schedule running smoothly and avoid delays.

Please note, if you have a **"managed care,"** insurance (Cigna Healthcare, HMO, Primecare Medicaid, PPO, Choice, etc...) our doctors **may** participate with your insurance plan, and if so, our practice must adhere to the rules of that plan. If your insurance plan states that you need a referral from your Primary Care Physician (PCP) it is **your** responsibility to obtain that referral. Please call your PCP prior to seeing one of our doctors to verify that a referral has been made. IF we have **not** received your referral by the time of your appointment, you may be asked to reschedule. We also ask that you please be prepared to pay your office visit co-pay (if any) at the time of your visit.

We recognize that our patients and their families may be stressed due to medical reasons and our goal is to make sure your appointment runs smoothly and on time. However, this is a surgical practice and from time to time an urgent surgery can disrupt our regular patient flow. If such a disruption occurs, you will be kept informed of the status of your appointment.

Please feel free to call with any questions.

Foot and Ankle Associates of Maine, P.A.

Health Information Sheet (1011)

Last Name_____First_____Initial_____Today's Date_____

Address_____City_____State_____Zip code_____

Mailing Address_____City_____State_____Zip code_____

Sex M___ F___ Birthdate_____ Age_____ Email address_____

Wt._____Ht._____Shoe size_____ Marital Status M D S W P Number of Children_____

Phone# _____ Primary Doctor (First)_____(Last)_____

Employer_____Occupation_____WorkPhone_____

Emergency Contact Name_____Phone #_____

Reason for visit _____ RT_____ LT_____
Have you been treated for this problem? No Yes ** If yes, date of treatment_____
What treatment was received? _____By whom? _____
Have you had X-rays taken for this problem? No Yes, when_____where_____
Is there any possibility that you are pregnant? No Yes

HAVE YOU EVER **Explain:**
Been operated on? ___No ___Yes _____
Been seriously injured? ___No ___Yes _____
Been on any type of disability? ___No ___Yes _____

SOCIAL HISTORY:
Do you smoke cigarettes? __No __Yes, how much? _less than 1 pack/day _1-2 packs/day _>3 packs/day
Do you use alcohol? __No __Yes, how much? ___ 1-2 drinks per day ___ More
Do you use recreational drugs __No __Yes

ALLERGIES: Please check all that apply

____None	____Aspirin	____Sulfa	____Other (please list)
____Penicillin	____Tape	____Latex (rubber)	_____
____Iodine dye	____Codeine	____Metal	_____

List all current medications you are taking:

_____ _____
_____ _____
_____ _____
_____ _____

Name & location of the Pharmacy you use_____

PERSONAL HISTORY: Check if **YOU** have had any of the following diseases, symptoms, or conditions

Arthritis	___Yes ___No	Back Injury/problem	___Yes ___No	Heart disease	___Yes ___No
Cancer	___Yes ___No	High Blood Pressure	___Yes ___No	Kidney disease	__Yes ___No
Stroke/Seizures	___Yes ___No	Immune Problems	___Yes ___No	Liver disease	__Yes ___No
Diabetes	___Yes ___No	Hepatitis	___Yes ___No	Blood Clots	___Yes ___No
Malignant Hyperthermia	___Yes ___No				

Review of Systems. Please check all that apply…

__unexpected weight loss
__weight gain
__fever
__chills
__fatigue
__corrective lenses
__blurred/double vision
__eye pain
__redness
__watering eyes
__headache_
__difficulty swallowing
__nosebleeds
__ringing in ears
__earaches
__chest pain

__palpitations
__fainting
__murmurs
__short of breath
__wheezing
__cough
__tightness
__inspiration pain
__snoring
__heartburn
__nausea
__vomiting
__dyspepsia
__ constipation
__ diarrhea
__ bloody/tarry stools

__painful urination/urgency
__ flank pain
__ bleeding
__ joint pains
__ swelling/redness/heat
__ instability
__ stiffness
__ muscle pain
__ skin changes
__ poor healing
__ rash
__itching/redness
__numbness/tingling
__unsteady gait
__dizziness
__tremors

__seizure
__nervousness
__anxiety
__depression
__hallucinations
__easy bleeding
__bruising
__excessive thirst
__excessive urination
__heat/cold intolerable
__reaction to food or environment

_____
Doctor's Signature

_____
Date

INSURANCE INFORMATION

Primary Insurance Company _____ Policy #_____
Subscriber's name on policy_____ Subscriber's birth date_____
Does your insurance company require pre-authorization? _____Yes _____No
Secondary Insurance Company_____ Policy #_____
Person responsible for patient _____Date of birth_____
Address _____

AUTHORIZATION FOR TREATMENT, ASSIGNMENT OF BENEFITS, AND RELEASE OF INFORMATION

I authorize FOOT AND ANKLE ASSOCIATION OF MAINE, P.A. and providers thereof to render treatment and to release any medical information (including information related to psychiatric care, drug/alcohol abuse, and HIV/AIDS) necessary to process claims, for any utilization review or quality assurance activities, or if and when applicable, as requested by subpoena, request for production of documents, or other court order, whether released verbally, written, or by fax. I assign all medical and /or surgical benefits including major medical benefits to which I am entitled for this or any other claim filed related to treatment received at FOOT AND ANKLE ASSOCIATES OF MAINE, P.A. **This assignment and authorization shall remain in effect unless revoked by me in writing.** A photocopy of this authorization shall be considered as effective and valid as the original. **I understand that, even though I may have some type of insurance coverage, I am responsible for payment of services.** I understand that if this account is placed with a collection agency, I will be responsible for the collection fee in the recovery of this account. I further understand that **as a person authorizing treatment for a minor child, I am responsible for the charges incurred** regardless of other agreement in place. By signing below, I am affirming that I have completed this form fully and that the information furnished is correct to the best of my knowledge. I am also affirming that I have read and understand the contents of the authorization above and my responsibilities therein. If I am insured by Medicare, I authorize any holder of medical or other information about me to be release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carrier, any information needed for this or a related Medicare claim whether verbal, written, or by fax. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits to the party who accepts assignment. Regulations pertaining to Medicare assignment of benefits apply.

X_____ **X**_____

Patient Signature **Date** **Person Giving Consent/ Relationship to Patient** **Date**