Cherry Creek Foot & Ankle Clinic

Dr. Florin Costache D.P.M, Dr. Lorry A. Melnick, D.P.M
Diplomate, American Board of Foot & Ankle Surgery

Patient Information

Date: _____
Name: _____
Address: _____
City: _____State: _____
Zip Code: _____ Phone:_____
Email:_____
Sex: Male_____ Female: _____
Date of Birth: _____
Please circle
Married -Widowed - Single -Minor
Spouse's Name: _____
Home Phone: _____
Cell Phone: _____
Best time to call: _____
In case of an Emergency:
Name: _____
Relationship: _____
Contact number: _____
How did you hear about us?
_____
_____

Podiatric History

What is the main complaint that came to be treated and when did the problem begin?
_____
_____
Duration:_____
Pain: 0 1 2 3 4 5 6 7 8 9 10
Height: _____ Weight: _____ Shoe size _____

History of Diabetes _____
Your occupation_____
How many hours do you spend on your feet?_____
Tobacco / cigarette consumption? _____

Indicate what foot problems you have or have had in the past.
Ankle pain _____Bunions _____ Athlete's foot _____
Flat foot _____ Warts _____Calluses _____
Heel pain ____Toe nails _____ Feet tired_____
Cramps or numbness____ Swelling _____
Trauma History:_____

Medications (prescription, over-the-counter) **Pharmacy Name**

	Name:
	Phone:

Please list any surgeries you have had:

_____

_____

Who is your family Physician? _____ ***Last Visit*****:** _____

***Doctors Notes**: _____

_____

_____

_____

_____

_____

_____

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	YES	NO		YES	NO		YES	NO
Aids/HIV			Epilepsy			Swelling ankles, feet		
Allergies to anesthetics			Eye problems			Tired feet		
Allergies to medicine or drugs			Fainting			Turberculosis		
Anemia			Leg cramps			Ulcers		
Angina			Gout			Vericose veins		
Artritis			Headaches			Wight gain / loss		
Artificial heart valves or joints			Heart disease			**ALLERGIES**		
Asthma			Hepatitis			Adhesive/Tape		
Back problems			High blood pressure			Aspirin		
Bleeding Disorders			Kidney problems			Anticoagulant Therapy		
Cancer			Liver disease			Codeine		
Chemical Dependency			Low blood pressure			Demerol		
Chest pain			Neuropathy			Iodine		
Chronic diarrhea			Radiation treatment			Novocain		
Circulatory problems			Rash			Local anasthetics		
Diabetes			Special diet			Penicillin		
Ear problems			Stroke			Seafood		
						Sulfa		

Treatment Consent

I hereby give my consent to give my permission to Dr. Costache / Dr. Melnick and the staff to administer and perform the procedures that the doctor deems necessary.

Signature: **Date:**

Insurance

Who is responsible for the account? _____Relationship to patient: _____
Insurance Co.: _____Grupo #: _____
Member I.d #: _____Date of birth: _____
SSN#: _____

Insurance disclaimer
"A benefit and / or authorization appointment does not guarantee payment or actual eligibility. The payment of benefits is subject to all the terms, conditions, limitations and exclusions of the member's insurance contact at the time of service."

Payment insurance responsibility: Your health insurance company will only pay for services you determine are "reasonable and necessary." The office will do everything possible to have all services and procedures previously authorized by your health insurance company, when prior authorization is required. If your health insurance company denies that a service is not included in your health insurance plan, your insurer will deny payment for that service.

Beneficial AdditiveI understand that my health insurance company denies payment for the services in the circumstances described above and for the reason that started. If my health insurance company denies the payment, I agree to be personally and fully responsible for the payment. I also understand that if my health insurance company makes the payment for the services, I will be responsible for any co-payment, deductible or co-insurance that is applied at the end of the service.

Signature: _____ Date: _____

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Notice of privacy practices and HIPAA contact sheet

I acknowledge that I was provided a copy of or access to the Notice of Privacy Practices. I have read or had the opportunity to read and understand the HIPAA notice of privacy practices.**Your Signature:** _____ **Date**: _____

Your provider and/or staff will at times need to contact you. By filling out the information below we will be better able to serve you.

Patients name (please print) _____

Person completing this form _____

Responsible party _____

Written, Phone & Phone messages consent

To protect your privacy, we have developed a policy in leaving medical care information.

We will **NOT** leave messages with anyone except the patient, legal guardian or responsible party.

We will **NOT** leave any confidential information on an answering machine.

We will **NOT** leave any messages on a voice mail.

We will **NOT** release medical treatment information or medical records without written consent.

UNLESS WE HAVE YOUR WRITTEN PERMISSION TO DO SO

Please read below and consider carefully whom you authorize to have access to protected information regarding your care.

I, _____ give ***Cherry Creek Foot Clinic*** my permission to speak with and/or leave phone messages regarding medical care and/or billing information with the following. I fully understand that this consent will remain valid until revoked on writing. Written documents include release of medical records and mailing of billing statement.

My home/cell answering machine: YES ( ) NO ( ) Initials: _____

My office/work voice mail: YES ( ) NO ( ) Initials: _____

Fax billing statement: YES ( ) NO ( ) Initials: _____

Persons we can communicate with and share medical and billing information to:

Name: _____ Relationship: _____ Initials: _____

Name: _____ Relationship: _____ Initials: _____