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: ______________
Legal Name: ____
Address: ____
City: _____________________________State: ____________
Zip Code: _____________ Phone:______________________

Email:____

Gender: Male / Female / Other
Date of Birth: ____________
Please circle: Married / Widowed / Single / Partner / Minor

Spouse / Partner Name: _____________________________
Phone: ____

In case of an Emergency:
Name: ____
Relationship: _______________________________________
Contact number: ____________________________________
How did you hear about us?
____
____

Podiatric History

Reason for Today's Visit:
____
____
____

Duration: ____
Location: ____
Onset (How did it start): ____________________________
____

Pain: 0 1 2 3 4 5 6 7 8 9 10
What Makes it Worse: ____________________________
What Makes it Better: ____________________________
Treatments: ____________________________________
____

Your occupation___________________________________

Smoking: Yes / No / Quit w/Date: ___________
Alcohol Use: None / Moderate / Heavy
Previous Foot / Ankle problems / Trauma History with Dates:
____
____

Medications (prescription, over-the-counter)	**Pharmacy Name / Address / Phone:**

Medical History (List all your medical problems): ______________________________________
____
____

Past Surgery History / Date / Include Childbirth: ___________________________________
____

Family History (medical problems): ____

Your Primary Care Physician (PCP): ________________________________ **Date Last Seen:** _____

Address / Phone #: ____
____

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Review of Systems: Do you have or have you had any of the following: (check all that apply)

	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		
Arthritis			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		
Clotting History								
Diabetes			Special diet			Penicillin		
Ear problems			Stroke			Seafood		
						Sulfa		
Other:						Other:		

Patient Name: ____ Date: _______________

Date Last Seen: ________

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Please DO NOT write below this area: **Staff / Physician Use Only**

VITALS: T: _____ P: ___ BP: ____ / ____ Wt.: _____/lbs Pain: ______/10

ALLERGIES: ____

S: Chief Complaint: ____

____

____

VASC:

NEURO:

DERM:

MSK/ORTHO:

X-RAY / Studies:

ASSESSMENT / DIAGNOSIS:

____

____

____

____

____

PLAN:

____

____

____

____

____

Treatment Consent

(Print Name): I ____, **Date of Birth**: _____________

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 medically necessary.

Signature: **Date:**

Insurance:

Who is responsible for the account? ______________________________Relationship to patient: _______________

Health Insurance: ______________________________________Group #: __________________________________

Member ID #: ___________________________________Date of birth: _____________________________________

SS#: ____

Insurance disclaimer

"A benefit and / or authorization for 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 contract at the time of service."

Payment insurance responsibility: Your health insurance company will only pay for services it determines to be "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. It is possible that your health insurance company may deny a service is not included in your health insurance plan.

Beneficial Additive 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**: ___________________

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.

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****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 & Ankle 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: _______________ Phone#: ______________________ Initials: ________

Name: ____________________ Relationship: _______________ Phone#: ______________________ Initials: ________

Patient Name: ____ Date: _________________