

C&S Foot and Ankle  
5676 Steubenville Pike  
McKee's Rocks, PA 15136  
412-787-1276/ fax 877-760-3852

Patient Name \_\_\_\_\_ Birthdate \_\_\_\_\_ Age \_\_\_\_\_ Sex \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ Zip Code \_\_\_\_\_

Marital Status \_\_\_\_\_ Race \_\_\_\_\_ Home Phone \_\_\_\_\_

Cell/Work \_\_\_\_\_ E-Mail \_\_\_\_\_

(If Minor) Fathers Name \_\_\_\_\_ Mothers Name \_\_\_\_\_

Patient Occupation \_\_\_\_\_ Employer \_\_\_\_\_

Insured Name (Policy holder's name) \_\_\_\_\_ & Birth date \_\_\_\_\_

Family Physician \_\_\_\_\_ Phone Number \_\_\_\_\_

Pharmacy \_\_\_\_\_ Location \_\_\_\_\_

Height \_\_\_\_\_ Weight \_\_\_\_\_ (yes fill this in) Shoe Size \_\_\_\_\_

Reason for today's Visit \_\_\_\_\_

Medication Allergies \_\_\_\_\_

Food Allergies \_\_\_\_\_ LATEX Allergy: Yes \_\_\_\_\_ No \_\_\_\_\_

List all Medications: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Have you ever had any of the following: PLEASE CHECK**

\_\_\_ Abnormal Bleeding \_\_\_ Acid Reflux \_\_\_ Anemia \_\_\_ Arthritis \_\_\_ Asthma \_\_\_ Back Problems

\_\_\_ Blood Clots \_\_\_ Cancer Type \_\_\_\_\_ \_\_\_ Circulation Problems \_\_\_ High Cholesterol \_\_\_ **Diabetes**

\_\_\_ Epilepsy \_\_\_ Fibromyalgia \_\_\_ Fractures \_\_\_ Gout \_\_\_ Heart Attack \_\_\_ Heart Disease

\_\_\_ Hepatitis \_\_\_ HIV/Aids \_\_\_ Hypertension \_\_\_ Kidney Disease \_\_\_ Liver Disease \_\_\_ Neuropathy

\_\_\_ Open Sores \_\_\_ Pregnancy \_\_\_ Phelbitis \_\_\_ Stroke \_\_\_ Thyroid Disease

Other \_\_\_\_\_

**Family Medical History** \_\_\_\_\_

**Past Surgeries:** Appendectomy \_\_\_ Breast \_\_\_ Cancer(Type) \_\_\_\_\_ Hernia \_\_\_ Hysterectomy \_\_\_ Knee \_\_\_  
Thyroid \_\_\_ Pace Maker \_\_\_ Tonsillectomy \_\_\_ Wisdom Teeth \_\_\_ Gallbladder \_\_\_ Other: \_\_\_\_\_

**Social History:**

Alcohol Use: Never \_\_\_ Quit \_\_\_ Rare \_\_\_ Occasional \_\_\_ Daily \_\_\_ Drinks per week \_\_\_\_\_

Caffeine Use: Never \_\_\_ Seldom \_\_\_ Daily \_\_\_ Cups per Day \_\_\_\_\_

Drug Use: Never \_\_\_ Quit \_\_\_ Frequency \_\_\_ Marijuana \_\_\_ Cocaine \_\_\_ IV drugs \_\_\_\_\_

Tobacco Use: Never \_\_\_ Quit \_\_\_ Social \_\_\_ Daily \_\_\_ Packs per Day \_\_\_ How many years \_\_\_\_\_

If you are a Diabetic: Are you currently under a comprehensive Diabetic treatment plan? Yes \_\_\_ No \_\_\_

Last Blood Sugar \_\_\_\_\_ Last A1C \_\_\_\_\_ Date of last PCP visit \_\_\_\_\_

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**Consent to Treatment:**

I understand that insurance claims may be submitted to my insurance on my behalf; however, I accept full financial responsibility for these claims regardless of my insurance company actions.

\_\_\_\_\_ X \_\_\_\_\_  
**Date Patient /or Guardian Signature**  
**Medicare**

\_\_\_\_\_ \_\_\_\_\_  
**Name of Beneficiary Medicare ID Number**

I request that payment of authorized Medicare benefits be made either to me or on my behalf to C&S Foot and Ankle for any services furnished to me by a physician or supplier in the Group (C&S). I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services.

\_\_\_\_\_ \_\_\_\_\_  
**Signature of Beneficiary Medigap**

\_\_\_\_\_ \_\_\_\_\_  
**Name of Beneficiary**

I request that payment of authorized Medigap benefits be made to either to me or on my behalf to C&S Foot and Ankle for any services furnished to me by any physician or supplier in the Group (C&S) I authorize any holder of Medicare information about me to release any information needed to determine these benefits payable for related services.

\_\_\_\_\_ \_\_\_\_\_  
**Signature of Beneficiary Privacy Notification**

I, \_\_\_\_\_, give permission to any physician and associate of the Group, C&S Foot and Ankle to leave information on an answering machine. I understand this may pertain to medical information. I also give permission for the following people to be given information, please circle all that apply.

**Spouse Mother Father Children Grandparents Other, please list names** \_\_\_\_\_

X \_\_\_\_\_ \_\_\_\_\_  
**Signature Date**

**Medical Record Policy**

I/We understand that all of the medical information collected including office notes, lab testing, and x-rays are the property of C&S Foot and Ankle. I/We understand that I/We have the right to obtain a copy of all medical records in AFCP's possession in compliance with HIPPA regulations, however, a written request must be presented to the office at least five(5) days in advance of disbursement. I/We also understand and agree to pay for all costs associated with copying the requested records prior to disbursement.

\_\_\_\_\_ X \_\_\_\_\_ \_\_\_\_\_  
**Patient Name Signature Date**