

Brett Chicko, DPM

Foot and Ankle Specialist

www.brettchickodpm.com

For Internal Use Only:

Scanned

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Intake

****Patient Information****

Date _____

Name _____
Last First Middle Initial

Address _____
Number Street Apt

City State Zip

*****Required—Please answer question below:*****

*****Marital Status (Please Circle):** Single / Married / Separated / Domestic Partner / Divorced / Widow

Home Phone: _____ Work Phone: _____

Cell Phone: _____ OK to receive Text? Yes / No

Email: _____

Date of Birth: _____ SS#: _____ - _____ - _____

Your Pharmacy Name/Address: _____
Name, Address or Phone Number

Social Information: It is a federal requirement that we ask the next questions. If you are uncomfortable answering any of these, you have the option to decline by leaving it blank.

Primary Language: _____

Race (Please Circle): American Indian or Alaskan Native / Asian / Black or African American /
Native Hawaiian or Other Pacific Islander / White

Ethnicity (Please Circle): Hispanic/Latino or Not Hispanic/Latino

Gender Identity (Please Circle): Male / Female / Transgender Male: Female-to-Male (FTM) /
Transgender Female: Male-to-Female (MTF) / Gender non-conforming (neither exclusively male nor
female) / Additional gender category; other, please specify _____ / Choose not to disclose

How did you hear about us (Please Circle):

Primary Care Doctor Insurance Company Friend/Family

Internet (choose one): Google Yahoo ZocDoc Our Website

Other (please specify): _____

Have you seen Dr. Chicko at one of his past practices? Yes / No

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What is the REASON FOR YOUR VISIT today? LIMIT 1-2 Reasons Per Appointment:

1. _____
2. _____

When did your symptoms start? _____

***** An office visit is not a guarantee of surgery. Patient must meet certain requirements/criteria at the discretion of Dr. Chicko before being able to schedule surgery.*****

Please list any ALLERGIES to MEDICATIONS:

Name: _____	Reaction: _____
Name: _____	Reaction: _____
Name: _____	Reaction: _____
Name: _____	Reaction: _____
Name: _____	Reaction: _____
Name: _____	Reaction: _____

Please list all MEDICATIONS you are currently taking including STRENGTH

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Height: _____ Weight: _____

Primary Care Doctor: _____

Name of Person or Practice

FAMILY HISTORY

(Please **V** and state which family member i.e.: father, mother, brother sister, **maternal or paternal** grandmother/grandfather, **maternal or paternal** aunt/uncle, etc.)

Alzheimer's _____

Anemia _____

Arthritis _____

Asthma _____

Back Problems _____

Cerebral Vascular Accident _____

Chronic Obstructive Pulmonary Disease _____

Coronary Arteriosclerosis _____

Deformity of Foot _____

Dementia _____

Diabetes Mellitus _____

Disorder of Thyroid _____

Epilepsy _____

Gout _____

Headache _____

Heart Disease _____

Hypocholesteremia _____

Hypertensive Disorder _____

Liver Problem _____

Malignant Neoplastic Disease _____

Migraine _____

Obesity _____

Osteoarthritis _____

Osteoporosis _____

Rheumatoid Arthritis _____

Seizure _____

Tuberculosis _____

Please fill out back page

SOCIAL HISTORY

Smoking Status (Please Circle):

Current every day smoker / Current some day smoker / Former Smoker/ Never Smoked

If current smoker, some day smoker, or former smoker:

How many years have you been smoking? _____ How much do you smoke? _____

Former Smoker: When did you quit? _____ How many years did you smoke? _____

Alcohol Use (Please Circle): None-do not drink / Occasional Drinker / Social Drinker / Heavy Drinker

Recreational Drugs: _____

Marital Status (Please Circle): Single / Married / Separated / Domestic Partner / Divorced / Widow

Please list any **surgeries/operations** you have had:

MEDICAL PROBLEMS

What **medical problems** do **you** have or **are you being treated** for? Please circle all that apply:

AIDS/HIV

Anemia

Arthritis

Artificial joints

Asthma

Back Pain

Bleeding disorder

Blood Clot

Cancer

Coronary Artery Disease

Deep Vein Thrombosis

Diabetes

Dialysis

Dyslipidemia

Edema

Fibromyalgia

Foot Deformity

Frost Bite

Gout

Headaches

Heart Disease

Hepatitis

Hernia

Hypertension

Kidney Disease

Leg or Foot Ulcers

Liver Disease

Lung Disease

Organ Transplant

Osteoporosis

Pacemaker

Peripheral Vascular Disease

Polio

Pulmonary Embolism

Raynaud's Disease

Rheumatoid Arthritis

Seizures/Epilepsy

Stroke

Substance Abuse

Thyroid Problems

Tuberculosis

Varicose Veins

Other Medical History: _____

Do you frequently experience or have you recently experienced any of the following symptoms? PLEASE CIRCLE:

- | | | | | |
|------------------------------|------------------------|-----------------------|----------------------------------|--------------|
| Constitutional: | Excessive Weight Gain | Excessive Weight Loss | Loss of Appetite | Fever |
| | Diminished Activity | Fatigue | | |
| Eyes: | Eye Pain | Blurry Vision | Eye Redness | Eye Swelling |
| EMNT: | Ear Pain | Hearing Loss | Sinus Pressure | Congestion |
| | Sore Throat | Hoarseness | Foul Smelling Breath | |
| Cardiovascular: | | Chest Pain | Rapid Heart Rate | |
| Chest/Breast: | Lumps | Tenderness | Discharge | |
| Respiratory: | Cough | Wheezing | Chest Tightness | |
| | Pain with Respirations | Rapid Respirations | Difficult Breathing | |
| Gastrointestinal: | Difficulty Swallowing | Abdominal Pain | Nausea | Vomiting |
| | Diarrhea | Constipation | Blood in Stool | |
| Genitourinary: | Blood in Urine | Painful Urination | Increased Frequency of Urination | |
| | Testicular Pain | Swelling | Redness | Masses |
| Musculoskeletal: | Soft Tissue Swelling | Joint Swelling | Limited Motion | |
| Skin: | Itchiness | Dry Skin | Redness | Rash |
| | Hives | Skin Lesions | Skin Growths | Skin Lumps |
| Neurological: | Numbness | Weakness | Tingling | Burning |
| | Headache | Dizziness | Loss of Consciousness | |
| Psychiatric: | Depression | Anxiety | Insomnia | Stress |
| Endocrine: | Increased Thirst | Increased Drinking | Temperature Intolerance | |
| Allergic/Immunologic: | | Sneezing | Runny Nose | |

I certify that the above information is true and correct to the best of my knowledge. I give my permission to Dr. Chicko to administer and perform such procedures as may be deemed necessary in the diagnosis and/or treatment of my feet, ankles and/or legs.

Signature: _____

Printed Name: _____ Date: ____/____/____

Please fill out back page

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Person to contact in case of emergency

Name _____ Relation to Patient: _____

Home Phone: _____ Cell Phone: _____

Financially Responsible Person

Name _____ Relation to Patient: _____

Phone: _____

Address: _____ Email: _____

Employer Name/Address _____

Other Persons to Notify in Emergency: _____ Phone: _____

Medical Insurance Coverage

(If you provide the staff with your Health Insurance Card(s), you do not have to fill out the information below)

Name of Primary Insurance _____

ID/Policy # _____ Group # _____

Policy Holder Name: _____ DOB: _____

Relationship to Holder: Self _____ Spouse: _____ Guardian: _____

Name of Secondary Insurance: _____

ID/Policy # _____ Group # _____

Policy Holder Name: _____ DOB: _____

Relationship to Holder: Self: _____ Spouse: _____ Guardian: _____

I understand and acknowledge that I am personally responsible for the services rendered at this facility. Brett Chicko, DPM Foot and Ankle Specialist will bill my insurance as a courtesy. In the event of non-payment, I understand I will be responsible for any outstanding balances.

Signature of Subscriber or beneficiary **Date**

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****Financial Policy****

(Please fill out back page)

NEW INSURANCE

Please notify us immediately if your insurance has changed.

COPAYMENT

Please know that all copayments are due at the time of your appointment.

COMPLETION OF FORMS

All forms to be completed by medical staff members (i.e. Workers Comp paperwork, FML, Disability, etc.) will be subject to a **\$25** charge that will be paid at the time in which the form is completed and received. There is no charge for a form that is completed during an office visit.

NO SHOW FEE

If you missed the scheduled appointment without notifying our office, a **\$25** charge will be added to your account.

RETURNING CHECK FEE

\$50.00 charge for all returned checks

ASSIGNMENT OF BENEFITS

I, the undersigned, certify that I (or my dependent) have insurance coverage with _____ and assign directly to Brett Chicko, DPM Foot and Ankle Specialist all insurance benefits, payable to me for services rendered. I understand that I am responsible for all information necessary to secure payment or benefits. I authorize **RELEASE OF MEDICAL INFORMATION** to my insurance carrier, any third party as it materially relates to services provided, or requested by physician to provide continuity of care. I authorize the use of this signature on all insurance submissions.

By my signature I acknowledge receipt of a copy of this policy and hereby agree to its terms.

Signature: _____

Printed Name: _____ Date: ____/____/____

Please fill out back page

Notice of Privacy Practices

(Please see Notice of Privacy Practices located in our office in the Waiting Room Area inside a blue binder. If you are unable to locate the Notice of Privacy Practice, please ask a staff member for a copy).

Right to Refuse Treatment:

You must notify a staff member if you are a Registered Sex Offender.

Family Foot and Ankle Center, LLC dba Brett Chicko, DPM Foot and Ankle Specialist, has the right to refuse treatment for any reason deemed necessary by the practice.

I acknowledge that I have read, understand and approve the above referenced document.

Signature: _____

Printed Name: _____ Date: ____/____/____