ANKLE & FOOT CENTERS OF MID-AMERICA
BRYAN M. SHEEHAN, D.P.M.

PATIENT INFORMATION

(Please fill in all information. All information is required for insurance purposes)

Name: _____ Date of Birth: _____ Age:_____
Last First MI

☐ Married ☐ Single ☐ Divorced ☐ Widowed Gender: _____ SSN: _____

Race:_____ Ethnicity: Hispanic/ Non Hispanic Driver License #: _____

Education:_____

Mailing Address: _____ Home Phone: _____

_____ Cell Phone: _____
City State Zip

Physical Address:_____

_____
City State Zip

E-mail Address: _____

Patient Employer: _____ Job Title: _____

Address: _____ Work Phone: _____

Spouse/Guardian Name: _____Date of Birth:_____

Employed by: _____ Bus. Phone: _____ SSN: _____

In case of an emergency we may contact (someone not living in your household):

Name &_____

Relationship: _____ Phone: _____

Family Physician: _____ Were you referred by him/her to us? Y/N

Date last seen by Physician: _____ how did you find out about our office? _____

(Women) To your knowledge, are you pregnant? _____ If so, Name of OBGYN _____

Do you have any drug allergies: Y / N If yes please list: _____

Are you Diabetic? Y / N If yes, do you take insulin? Y / N

PLEASE PRESENT YOUR ISURANCE INFORMATION TO RECEPTIONIST FOR A COPY

Insurance and Treatment Authorization: I assign all insurance benefits to Ankle & Foot Centers of Mid-America for services rendered. I understand that I am financially responsible for all charges whether or not paid by Insurance. I herby authorize AFCMA to furnish and release all information to insurance carriers concerning my illness and treatments. I authorize the use of this signature on all insurance submissions. I acknowledge and understand that there is a $15.00 fee for all return checks. I authorize treatment and procedures by physician and by member of staff to the above listed patient. I certify that all information contained on this form is true and correct to the best of my knowledge.

Signed: _____ Date _____
(Patient or responsible party)

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PODIATRIC HISTORY

This information is important for our records and your health.

Name: _____

Describe your foot problem: _____

_____

How long has it been bothering you? _____ Days _____ Weeks _____ Years

Please indicate which foot problems you now have or have had in the past.

FOOT OR ANKLE PAIN	☐ Y / N ☐	ATHLETE'S FOOT	☐ Y / N ☐
BUNIONS	☐ Y / N ☐	CIRCUALTION PROBLEMS	☐ ☐
CORNS & CALLUSES	☐ Y / N ☐	IN FEET OR LEGS	☐ Y / N ☐
CRAMPS OR NUMBNESS	☐ ☐	FLAT FEET	☐ Y / N ☐
IN FEET OR LEGS	☐ Y / N ☐	HEEL PAIN	☐ Y / N ☐
HAMMERTOES	☐ Y / N ☐	PLANTAR WARTS	☐ Y / N ☐
INGROWN TOENAILS	☐ Y / N ☐	TIRED FEET	☐ Y / N ☐
SWELLING IN ANKLES	☐ Y / N ☐	SWELLING IN FEET	☐ Y / N ☐

Have you ever been to a Podiatrist before? Y / N If yes, please list.

Name of Podiatrist: _____ last visit: _____

Any past surgical procedures on your feet or ankles? _____

_____

Shoe Size _____ Current weight _____ Height _____

Are you allergic or sensitive to any medicines? Y / N If yes, please list: _____

Please mark all items you are allergic or sensitive to:

Adhesive / Tape	____	Anticoagulant Therapy	____
Aspirin	____	Codeine	____
Demerol	____	Iodine	____
Local Anesthetics	____	Novocaine	____
Penicillin	____	Seafood's	____
Sulfa	____	Other _____	

Current Medications:

List medications you are taking, including prescriptions, over-the-counter medications, and vitamins: _____

_____

_____

Pharmacy Name: _____ Phone: _____

Do you take oral contraceptives? Y / N

List any previously taken anti-inflammatory? _____

MEDICAL HISTORY

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Name: _____

Please circle as to if your or a family member has had any of the following:

S= Self M= Mother F= Father

AIDS/HIV		Diabetes		Radiation	
Allergies to anesthetics		Ear problems		Rash	
Allergies to Medicine		Epilepsy		Respiratory disease	
Anemia		Eye problems		Rheumatic Fever	
Angina		Back problems		Sinus problems	
Arthritis		Bleeding disorders		Shortness of breath	
Artificial heart valves		Cancer		Special Diet	
Artificial joints		Chemical dependency		Stroke	
Asthma		Chest pain		Swelling ankles/ feet	
Fainting		Chronic diarrhea		Swollen neck glands	
Foot or leg cramps		Circulatory problems		Tired feet	
Gout		Kidney problems		Tuberculosis	
Heart Disease		Liver disease		Ulcers (peptic, stomach)	
Hemophilia		Low blood pressure		Varicose Veins	
Hepatitis or Jaundice		Nervous problems		Veneral Disease	
High blood pressure		Phlebitis		Weight loss, unexplained	
Headaches		Psychiatric Care			

Surgeries you have had: _____

_____

_____

Hospitalization other than for the surgeries listed: _____

_____

_____

Are you under a physician's care? Y/N If yes, for what condition(s): _____

_____

_____

Family Physician: _____ Date of last visit: _____

May we contact your physician about your health? Y / N

Do you smoke? ____ If yes, # of packs per day: _____ previously smoked? Y / N

# of year's since you stopped? ____ Do you drink alcohol or beer? Y / N

___ Light usage, 1-2 per week ___ Moderate, 1-2 per day ___Heavy, more than 2 daily

Employment: ___sits at job, ___ stands at job, ___ stands & walks at job, ___ retired

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

Patient signature:_____ Date: _____

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DURABLE MEDICAL EQUIPMENT

Most insurance companies (including Medicare) **DO NOT** cover Supplies or Durable Medical Equipment. In our office we dispense both Supplies and Durable Medical Equipment, which include some of the following:

Accommodative Orthotics	**Lotions**
Ankle Braces	**Misc. Medications**
Antibiotic Cream	**Night Splint**
Coflex	**Removable Cast**
Corn Pads	**Strapping**
Functional Orthotics	**Surgical Shoes**
Heel Cups	**Toe Caps**
Heel Pads	**Toe Pads**

We will gladly file your insurance for these items, but you are responsible for payment. We expect payment for both Supplies and Durable Medical Equipment at the time it is dispensed.

Signature of patient / responsible party Date

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

The attached Notice of Privacy Practices describes how the Ankle & Foot Centers of Mid-America may use and disclose your medical information and how you can get access to this information. Please review it carefully. If you have any questions about the Privacy Notice of Privacy Practices, please contact our Privacy Officer at (918) 787-6893.

ACKNOWLEDGEMEN OF NOTICE OF PRIVACY PRACTICES

A complete copy of the Facility's Notice of Privacy Practices is attached hereto and posted in the Facility. By signing below you acknowledge that you have received a copy of the Facility's Notice of Privacy Practices.

Signature of Patient: _____ Date: _____

Time: _____

IF PATIENT IS A MINOR OR INCOMPETENT

I hereby acknowledge that I have received a copy of the Facility's Notice of Privacy Practice on behalf of the patient.

Signature of Person Authorized to Consent for Patient: _____

Date: _____

Relationship to Patient: _____

Time: _____

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Cancellation/Missed Appointment Policy

Our goal is to provide quality medical care in a timely manner. In order to do so, we have had to implement an appointment/cancellation policy. This policy enables us to better utilize available appointments for our patient in need of medical care.

Cancellation of an Appointment:

In order to be respectful of the medical needs of other patients, please be courteous and call Ankle & Foot Centers of Mid-America promptly if you are unable to attend an appointment. This time will be reallocated to someone who is in urgent need of treatment. If it is necessary to cancel your scheduled appointment, we require that you call at least 24 hours in advance. Appointments are in high demand, and your early cancellation will give another person the possibility to have access to timely medical care.

How to Cancel Your Appointment:

To cancel appointments, please call 918 787-6893 or 479 224-6411. If you do not reach the receptionist you may leave a detailed message on the voice mail. If you would like to reschedule your appointment, please be sure to leave your phone number and let us know the best time to return your call.

Late Cancellations:

Late cancellations will be considered as a "no-show".

No-Show Policy:

A "no-show" is someone who misses an appointment without cancelling it in an adequate manner. "No-Shows" inconvenience those individuals who need access to medical care in a timely manner. A failure to present at the time of a scheduled appointment will be recorded in the patient's chart as a "no-show". The first time there is "no-show", there will be no charge to the patient. Any additional "no-show" will result in a fee of $40.00 billed to the patient.

_____

Patient Signature/Responsible Party