The Centers for Advanced Orthopaedics
The Orthopaedic Foot & Ankle Center

Name:	Date of Birth: Sex:
Address One:	Home Phone #:
Address Two:	Work Phone #:
City:	Cell Phone #:
State: Zip:	Emergency Contact
Social Security #:	Emergency Phone #:
Marital Status: _____Single _____ Married _____Divorced _____ Widowed ____Separated Employment: _____Full time _____Part time _____ Not Employed _____ Student	Email Address: How did you hear about us: Primary Care Physician:
Ailment: Injury:	Date of first Symptom: Date of injury:
Race: ____Unreported/Refused to report _____Asian _____Native Hawaiian _____White (Not Hispanic or Latino) _____Other Pacific Islander _____American Indian/Alaska Native _____Black/African American (Not Hispanic or Latino)	Ethnicity: ______ Hispanic ______ Not Hispanic or Latino ______ Refused to report Language: _____ English _____ Spanish _____ Arabic______ American Sign Language ______Chinese ______________________Other

GUARANTOR INFORMATION

Name:	Date of Birth:
Address One:	Social Security #:
Address Two:	Home Phone #:
City:	Work Phone #:
State: Zip:	Cell Phone #:

INSURANCE INFORMATION

Primary Insurance:	Secondary Insurance:
Certificate #:	Certificate #:
Group Number:	Group Number:
Subscriber Name:	Subscriber Name:
Subscriber DOB:	Subscriber DOB:
Subscriber Relationship:	Subscriber Relationship:

Authorization to Pay Benefits to Physician: I authorize the release of medical or other information necessary to process health insurance claims. I also request payment of benefits to myself or to my Provider, Orthopaedic Foot & Ankle Center when he accepts assignment.

Authorization to Release Medical Information: I hereby authorize my Provider, Orthopaedic Foot & Ankle Center- A Division of The Centers for Advanced Orthopaedics (OFAC/OFAC-CAO to release any information necessary for my course of treatment.

I am aware of my HIPAA Rights (you can request a copy of your privacy rights at the front desk)

_______________________________________ ____________________

Signature (patient or guardian if minor) Date

The Centers for Advanced Orthopaedics
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Financial Policies

We are committed to providing you with the best possible care and are pleased to discuss our professional fees with you at any time. Your clear understanding of our Financial Policy is important to our professional relationship. Please ask if you have any questions about our fees, or your financial responsibility. The patient or responsible party is responsible for seeing that the entire bill is paid in full. Responsible parties will be responsible for any collection fees, interest, and other expenses necessary to collect on any account, including court costs, should legal action be necessary to collect.

We will ask to see your insurance card on your first visit and will scan your card into our system as needed to keep our information current. We will ask for this information at every visit, in order to ensure that no change in benefits or carrier has occurred. Please notify us if your insurance carrier or policy has changed. Billing of insurance is a courtesy we provide for patients and is not required by law.

PLEASE READ AND INITIAL EACH LINE BELOW ACKNOWLEDING YOU HAVE READ ALL POLICIES.

______**COPAYMENTS**: Your insurance **REQUIRES** that we collect your designated co-pay at the time of service. Please be prepared to pay the co-pay at each visit.

______**DEDUCTIBLES AND CO-INSURANCE**: We may collect your deductible and co-insurance at the time of service. OFAC will bill your insurance company. Patient Responsibility portions of your bill are to be paid within 90 days.

______**SELF-PAY/UNINSURED**: Self-pay accounts shall exist if a patient has no insurance coverage or no evidence of insurance coverage. For new patients, a payment of **$250.00** is required on the day of your appointment before being seen by the health care provider. If you are unable to pay the **$250.00** please contact the billing office prior to your appointment. A discount off regular fees is offered for payment made at time of service.

______**REFERRALS**: If your insurance plan requires a referral from your primary care physician it is your responsibility to obtain it prior to your appointment and to have it with you at the time of the appointment. If you do not have your referral, **YOU MAY BE REQUIRED TO RESCHEDULE**.

______**RETURNED CHECK FEES**: Any returned check from the bank for non-payment (insufficient funds) shall result in the patient's account being assessed a **$40.00** fee per check returned.

_______**FORMS/PAPERWORK**: There is a **$40.00 pre-payment** per form fee for the completion of paperwork or forms relating to disability, FMLA, etc. This fee is collected prior to completion of the paperwork, and for each time the paperwork is required. Allow seven working days for completion of forms. **Any forms needed within 48 hours from the time it was given to our staff will need to pre-pay an additional $20.00 rush fee.**

_______ **DMV HANDICAP PARKING APPLICATIONS:** There is a $10.00 fee for **ALL** DMV handicap parking applications.

_______**NO SHOW FEE**: You will be charged a **$35.00 fee** if you fail to cancel your appointment with 24 hours of your scheduled appointment or do not show for your scheduled appointment.

_______**SURGERY CANCELATION FEE**: Any surgeries cancelled within 7 business days of the scheduled surgery date will incur a **cancellation fee of $500.00. (Fee will be waived if surgery is canceled due to a death in the family, illness or if the patient is not cleared for surgery)**

RESPONSIBLE PARTY SIGNATURE: ____________________________________**DATE**: _________________

Patient Name (if different from Responsible Party): ____

The Orthopaedic Foot & Ankle Center

Patient statement: To the best of my knowledge, the information I will provide is accurate and complete.

Signed: ____ Date: ______________________

I am aware of my HIPAA Rights (you can request a copy of your privacy rights at the front desk)

Signed: ____ Date: ______________________

I would prefer to be reached by:

Home Phone _____ Cell phone_____ Home Voicemail _____ Patient Portal ______

May we leave a message with a family member? Yes _____ No _____

Signed: ____ Date: ______________________

Please list any family members that we can release information to:

Name __________________________________ Relation _________________________________

Name __________________________________ Relation _________________________________

Signed: ____ Date: ________________________

Please list any physicians/ individuals that you want your medical records release to:

_____________________________________ ____

_____________________________________ ____

Signed: ____ Date: ________________________

I give permission to the Orthopaedic Foot & Ankle Center, a Division of The Centers for Advanced Orthopaedics, to obtain copies of my medical records:

This field is optional, sign if you want the Orthopaedic Foot & Ankle Center to obtain copies of your medical records from other physician offices.

Signed: ____ Date: ________________________

The Orthopaedic Foot & Ankle Center

Provider / Patient #:

(Office Use Only)

How did you hear about us?

We would sincerely appreciate if you could take a few moments to complete the following questionnaire.
This information will be used to improve our outreach program.
Thank you for your time!

- ☐ A referring doctor
  Name: ____________________

*****If a doctor did not refer you to our practice, please check an option below:**

- ☐ A friend or relative who was a patient
  Name: ____________________
- ☐ Magazine article or advertisement
  Please specify: ____________________
- ☐ Google / Internet Search
- ☐ Insurance Carrier: ____________________
- ☐ Facebook
- ☐ Yelp!
- ☐ The Washington Ballet
- ☐ Community Events & Sponsorships
  Please specify: ____________________
- ☐ Other: ____________________

CAO

The Centers
for Advanced Orthopaedics

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Patient Information	Last:		First:	MI:	Date:
	SS#:	DOB:	Gender: ◯ M ◯F		Preferred Name:
Race:	◯ Decline ◯ Black or African American		◯ Asian ◯ American Indian or Alaskan Native		
	◯ White ◯ Other (please specify) ____________________				
Language:	◯ English ◯ Spanish	◯ French ◯ Arabic	◯ Decline ◯ Other (please specify)____________		
Ethnicity	◯ Hispanic or Latino	◯ Not Hispanic or Latino	◯ Unknown ◯ Decline to Specify		
Referring Doctor:	Last Name:		First Name:		
PCP:	Last Name:		First Name:		
How did you hear about OFAC?	◯ Friend or Family	◯ Internet	◯ Insurance	◯ Facebook	
	◯ Returning patient	◯ Magazine	◯ Yelp	◯ Other:____________	
Pharmacy Information	Name of Pharmacy:		Phones #: ( )		
	Address or Street Name:		City:		
Vitals:	Height:________inches	Weight: ________ lbs.	Shoe Size: ________	Hand Dominance: ◯Right ◯Left ◯Both	
Review of Systems	◯ **I have NO other symptoms or complaints**				
	(please check all that apply)				
General:	◯ Fatigue	◯ Recent Weight Change	◯ Night Sweats	◯ Unable to sleep lying flat	
Skin:	◯ Change hair or nails	◯ Rashes or Itching	◯ Course Skin	◯ Cold Skin	
HEENT:	◯ Hearing loss or ringing	◯ Blurred Vision	◯ Nose Bleeds	◯ Wears Glasses/Contacts	
Respiratory:	◯ Cough	◯ Couging up blood	◯ Shortness of breath	◯ Wheezing/Asthma	
Breast:	◯ Breast Pain	◯ Breast Lump	◯ Breast Discharge		
Cardiovascular:	◯ Cheast Pain	◯ Heart Trouble	◯ Swelling Hands/Feet	◯ Palpitations	◯ Murmur
Gastrointestinal:	◯ Bowel Problems	◯ Abdominal Pain	◯ Nausea	◯ Rectal Bleeding	◯ Vomiting
Genitourinary:	◯ Blood in Urine	◯ Kidney Stone	◯ Menstrual Irregularities	◯ Sexual Problems	◯ Testicle Pain
Musculoskeletal:	◯ Joint Pain	◯ Muscle Pain or Cramps	◯ Stiffness/Swelling Joints	◯ Trouble Walking	
Neurological:	◯ Convulsions/Seizures	◯ Frequent headaches	◯ Numbness/Tingling	◯ Paralysis or tremors	
Psychiatric:	◯ Confusion/Memory Loss	◯ Bipolar Disorder	◯ Depression	◯ Insomnia	
Endocrine:	◯ Excessive Thirst	◯ Hormone Problem	◯ Excessive Urination	◯ Thyroid Problems	
Hematology:	◯ Abnormal Bleeding	◯ Anemia ◯ Blood Clots	◯ Easy Bruising	◯ Enlarged Glands	◯ Slow to Heal
Past Medical History	◯ **I have NO Relevant medical history**			*Special Orthopaedic Alert	
	◯ *AIDS/HIV	◯ Congestive Heart Failure	◯ Fibromyalgia	◯ MI/Heart Attack	◯ Scoliosis
	◯ Alzheimer's	◯ COPD/Emphysema	◯ *Hepatitis	◯ Obesity	◯ Seizures
Please Check all that apply	◯ Anemia	◯ Coronary Artery Disease	◯ High Blood Pressure	◯ Osteoporosis	◯ *Sleep Apnea
	◯ Arthritis	◯ Depression	◯ High Cholesterol	◯ Parkinson's	◯ Stroke
	◯ Asthma	◯ *Diabetes	◯ Gout	◯ *Previous MRSA	◯ Thyroid Disease
	◯ *Blood Clot	◯ Excessive Bleeding	◯ *Kidney Disease	◯ Psoriasis	
	◯ Cancer, Type: ____________		◯ *liver Disease	◯ Pulmonary Embolism	
	◯ Other: ______________________________				

Patient Name:

Allergies

◯ **I have NO Medication / food allergies**

◯ Adhesive	◯ Demoral	◯ Iodine	◯ Novacaine	◯ Pollen
◯ Ampicillin	◯ Dust	◯ Latex	◯ NSAIDs	◯ Prednisone
◯ anesthesia	◯ Eggs	◯ Mold	◯ Peanut	◯ Shellfish
◯ Celebrex	◯ Feathers	◯ Morphine	◯ Penicillin	◯ Sulfa Drug

◯ Other: ____

Family History

◯ **I have NO relevant family history** M = Mother F = Father B = Brother S = Sister

Arthritis	◯ M ◯F ◯B ◯S	High Arches	◯ M ◯F ◯B ◯S
Bunion	◯ M ◯F ◯B ◯S	High Cholesterol	◯ M ◯F ◯B ◯S
Cancer	◯ M ◯F ◯B ◯S	Hypertension	◯ M ◯F ◯B ◯S
Coronary Artery Disease	◯ M ◯F ◯B ◯S	Neuropathy	◯ M ◯F ◯B ◯S
Diabetes	◯ M ◯F ◯B ◯S	Osteoporsis	◯ M ◯F ◯B ◯S
Flat Feet	◯ M ◯F ◯B ◯S	Sickle Cell Disease	◯ M ◯F ◯B ◯S
Hammertoe	◯ M ◯F ◯B ◯S	Other:_______________	◯ M ◯F ◯B ◯S

Social History

Alcohol Use:	◯ Rare	◯ Occasional	◯ Moderate	◯ Heavy	◯ No alcohol Use	
Tobacco Use:	◯ Never	◯ Some Day	◯ Every Day	◯ Former	◯ Decline to answer	
Recreational Drug Use:	◯ Never	◯ Recent quit	◯ Socially	◯ Daily	◯ Type ______________________	
Exercise:	◯ Inactive	◯ Light	◯ Moderate	◯ Heavy	◯ Inactive due to current symtoms	
Martial Status:	◯ Single	◯ Married	◯ Separated	◯ Divorced	◯ Widowed	◯ Partnership

Occupation: ____

Current Medications

Please list all prescriptions, over-the-counter, birth control, blood thinners, vitamins and supplements

◯ **I do NOT take any medications.**

Medication / Vitamin / Supplement Name:	Dosage:	Times per day:

Surgical History

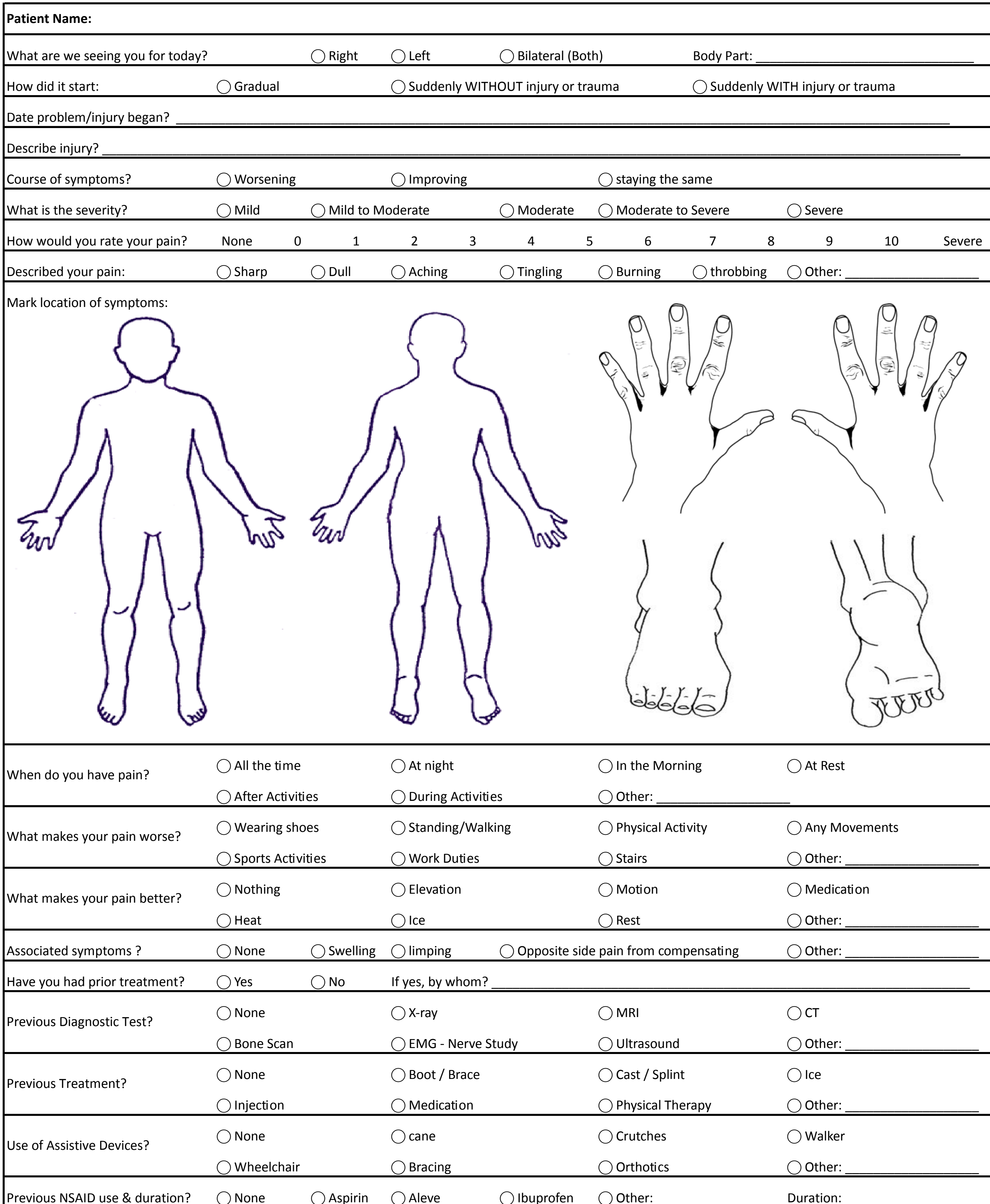
◯ **I have NO Relevant surgical history**

Have you ever had problems with anesthesia? ◯Yes ◯No R = Right L = Left B = Bilateral (both)

Name of Surgery	Side	Name of Surgery	Side
	◯ R ◯L ◯B		◯ R ◯L ◯B
	◯ R ◯L ◯B		◯ R ◯L ◯B
	◯ R ◯L ◯B		◯ R ◯L ◯B
	◯ R ◯L ◯B		◯ R ◯L ◯B
	◯ R ◯L ◯B		◯ R ◯L ◯B

Are you pregnant or have a chance of being pregnant? ◯ Yes ◯ No

Do you have a history of falling within the past year? ◯ Yes ◯ No



Patient Name:

What are we seeing you for today? ◯ Right ◯ Left ◯ Bilateral (Both) Body Part: ______________________________

How did it start: ◯ Gradual ◯ Suddenly WITHOUT injury or trauma ◯ Suddenly WITH injury or trauma

Date problem/injury began? ______________________________

Describe injury? ______________________________

Course of symptoms? ◯ Worsening ◯ Improving ◯ staying the same

What is the severity? ◯ Mild ◯ Mild to Moderate ◯ Moderate ◯ Moderate to Severe ◯ Severe

How would you rate your pain? None 0 1 2 3 4 5 6 7 8 9 10 Severe

Described your pain: ◯ Sharp ◯ Dull ◯ Aching ◯ Tingling ◯ Burning ◯ throbbing ◯ Other: __________________

Mark location of symptoms:

When do you have pain? ◯ All the time ◯ At night ◯ In the Morning ◯ At Rest ◯ After Activities ◯ During Activities ◯ Other: __________________

What makes your pain worse? ◯ Wearing shoes ◯ Standing/Walking ◯ Physical Activity ◯ Any Movements ◯ Sports Activities ◯ Work Duties ◯ Stairs ◯ Other: __________________

What makes your pain better? ◯ Nothing ◯ Elevation ◯ Motion ◯ Medication ◯ Heat ◯ Ice ◯ Rest ◯ Other: __________________

Associated symptoms ? ◯ None ◯ Swelling ◯ limping ◯ Opposite side pain from compensating ◯ Other: __________________

Have you had prior treatment? ◯ Yes ◯ No If yes, by whom? ______________________________

Previous Diagnostic Test? ◯ None ◯ X-ray ◯ MRI ◯ CT ◯ Bone Scan ◯ EMG - Nerve Study ◯ Ultrasound ◯ Other: __________________

Previous Treatment? ◯ None ◯ Boot / Brace ◯ Cast / Splint ◯ Ice ◯ Injection ◯ Medication ◯ Physical Therapy ◯ Other: __________________

Use of Assistive Devices? ◯ None ◯ cane ◯ Crutches ◯ Walker ◯ Wheelchair ◯ Bracing ◯ Orthotics ◯ Other: __________________

Previous NSAID use & duration? ◯ None ◯ Aspirin ◯ Aleve ◯ Ibuprofen ◯ Other: __________________ Duration:__________________

Patient Statement: To the best of my knowledge, the information provided is accurate and complete.

Signature: ______________________________ **Print Name:** ______________________________ Date: ____________________

Patient Name:

Only complete this section if you are 50 years old or older AND being seen for a lower extremity issue.

Why? People who are 50 years or older AND are positive for specific risk factors are at an increased risk for Peripheral Arterial Disease or PAD.

What is PAD? Peripheral artery disease (also called peripheral arterial disease) is a common circulatory problem in which narrowed arteries reduce blood flow to your limbs.

Yes / No Do you have foot, calf, buttock, hip, thigh discomfort while walking that is relieved by rest?

Yes / No Do you have foot or toe pain that wakes you up at night?

Yes / No Do you have pain in your lower leg(s) or feet when you are at rest?

Yes / No Are your toes or feet pale, bluish or discolored?

Yes / No Do you or have you had wounds or ulcers on your toes or feet that are slow to heal?

Yes / No Has a doctor ever told you that you have diminished or absent foot pulses?

Yes / No Have you ever had a severe injury to your legs or feet?

Yes / No Do you currently have a gangrenous infection of your legs or feet?

Yes / No Do you have a history of Heart Disease?

Yes / No Have you had a stroke?

Yes / No Have you ever smoked?

Yes / No **MEN ONLY** - Have you lost the hair on your legs?