Haag Foot & Ankle, PLLC

Dr. Cheryl Haag, Dr. Kevin Haag & Dr. Lester Haag
Specializing in Diseases & Surgery of the Foot & Ankle
4957 Swinyar Dr. Suite 105, Ooltewah, TN 37363 423-396-3668 FAX 423-396-2436

Patient History and Intake Form

Last Name: _____ First Name:_____ Middle Initial: _____

Nickname: _____ Marital Status: _____ Occupation: _____

Date of Birth: _____ Age: _____ Gender: _____ Social Security#: _____

Address: _____ City / State / Zip: _____

Preferred Phone#: _____ Home or Mobile *(please circle)*
If mobile, may we text you? Yes or No *(please circle)*

Alternate#: _____ Email: _____

Guarantor: _____ Relationship to Pt: _____
(Required for minor / dependent)

Phone Number: _____ Gender: _____ DOB: _____

Emergency Contact: _____

Relationship to you: _____ Phone Number: _____

Pharmacy Name & Number: _____

Address: _____

Primary Care Doctor: _____
(First Name, Last Name, Phone Number)

Address: _____ Date Last Seen: _____

ALERTS

Place a " √ " below if you have any of the following:

Pacemaker	
Blood thinners	
HIV	
Hepatitis	
Allergy to shellfish/iodine	
Allergy to latex	
Allergy to adhesive	
Under pain management	

_____ _____
Signature of Patient or Guardian/POA ***Date***

Please print your name: _____

PAST MEDICAL CONDITIONS

Check any of the following medical conditions you currently have:

- ☐ NONE
- ☐ Anxiety disorder
- ☐ Arthritis
- ☐ Asthma
- ☐ Atrial fibrillation
- ☐ Cerebrovascular accident
- ☐ Chronic obstructive lung Disease
- ☐ Coronary arteriosclerosis
- ☐ Depressive disorder
- ☐ Diabetes mellitus
- ☐ Elevated blood pressure
- ☐ End-stage renal disease
- ☐ History of Hypertension
- ☐ Human Immunodeficiency Virus infection
- ☐ Thyroid disease
- ☐ Inflammatory disease of the liver
- ☐ Leukemia
- ☐ Malignant lymphoma
- ☐ Malignant tumor of colon
- ☐ Cancer_____
- ☐ Nerve disorder_____
- ☐ Other _____

_____

REVIEW OF SYSTEMS

Check any of the following symptoms you currently have:

Symptom	Yes	Symptom	Yes	Symptom	Yes
Joint Pain		Dizziness		Cough	
Joint swelling		Fatigue		Fever	
Joint stiffness		Unexpected weight loss		Weight gain	
Unsteady gait		Rash		Heart murmur	
Numbness		Itching		Leg cramps	
Tingling		Easy bleeding		Shortness of breath	
Headaches		Easy bruising		Poor healing wounds	

PAST SURGERIES

Have you had any of the following surgeries?

- ☐ NONE
- ☐ Bilateral replacement of knee joints
- ☐ Coronary artery bypass graft
- ☐ Excision of basal cell carcinoma
- ☐ Excision of melanoma
- ☐ Excision of squamous cell carcinoma
- ☐ History of liver excision
- ☐ History of percutaneous transluminal coronary angioplasty
- ☐ History of tissue heart graft valve replacement
- ☐ Mechanical heart valve replacement
- ☐ Prosthetic arthroplasty of bilateral hips
- ☐ Surgical biopsy of the skin
- ☐ Total replacement of left hip joint (circle Left or Right)
- ☐ Total replacement of left knee joint (circle Left or Right)
- ☐ Other _____

Please Initial: _____

PODIATRIC FOOT/ANKLE - DISEASE HISTORY

Have you had any of the following foot or ankle problems?

- ☐ NONE
- ☐ Bursitis
- ☐ Flat feet
- ☐ Ankle ulcer
- ☐ Bone tumor
- ☐ Chronic pain
- ☐ Deep venous thrombosis
- ☐ Foreign body
- ☐ Fracture of bone
- ☐ Bunion
- ☐ Carpal Tunnel Syndrome
- ☐ Laceration - injury
- ☐ Cellulitis
- ☐ Cancer of soft tissue
- ☐ Neuroma of foot
- ☐ Osteoarthritis
- ☐ Peripheral nerve disease
- ☐ Peripheral vascular disease
- ☐ Peripheral venous insufficiency
- ☐ Plantar fasciitis
- ☐ Gout
- ☐ Recurrent falls
- ☐ Rheumatoid Arthritis
- ☐ Ankle sprain
- ☐ Ulcer of foot
- ☐ Other _____

_____

_____

PODIATRIC FOOT/ANKLE - SURGICAL HISTORY

Have you had any of the following?

- ☐ NONE
- ☐ Amputation of any kind
- ☐ Fusion of ankle
- ☐ Fusion of foot
- ☐ Arthroscopy of ankle
- ☐ Treatment of warts
- ☐ Decompression of tarsal tunnel
- ☐ Excision of neuroma
- ☐ Excision of tumor of extremity
- ☐ Fasciotomy of foot
- ☐ Hammer toe repair
- ☐ Lengthening of tendon
- ☐ Childhood foot surgery
- ☐ Nail plate procedure
- ☐ Surgery of broken bone
- ☐ Removal of foreign body
- ☐ Bunion surgery
- ☐ Repair of tendon
- ☐ Other _____

_____

PODIATRIC FOOT/ANKLE - FAMILY HISTORY

Is there a history of any of the following in your immediate family?

- ☐ NONE
- ☐ Charcot foot
- ☐ Congenital deformity of foot
- ☐ Flat feet
- ☐ Bunion
- ☐ Acquired cavus deformity of foot
- ☐ Osteoporosis
- ☐ Hammer toe
- ☐ Other _____

_____

Please Initial: _____

MEDICATIONS

☐ Not currently taking any medication(s) -OR-

Please list ALL current medications below. (we will try to download your medication history from your pharmacy)

Medication	Dosage	Frequency

ALLERGIES

Please list ALL known allergies below -OR-

☐ Check box if No Known Allergies

Using the following options, describe your reaction(s) with severity provided below

Reaction Types			Severity Scale
Anaphylaxis	Angioedema	Diarrhea	Mild
Dizziness	Fatigue	GI upset	Mild to Moderate
Hives	Liver toxicity	Nausea	Moderate
Rash	Shortness of breath	Swelling	Moderate to Severe
Weal	Other: (please describe)		Severe
			Fatal

	Allergy	Reaction(s)	Severity
1.)			
2.)			
3.)			
4.)			
5.)			

Please Initial: _____

SOCIAL HISTORY

Race (please choose one):

- ☐ Asian
- ☐ Black
- ☐ Hispanic/Latino
- ☐ White
- ☐ Other _____

What is your primary language?

_____

Alcohol Intake (please choose one):

- ☐ NONE
- ☐ 1 or less per day
- ☐ 1-2 per day
- ☐ 3 or more per day

Smoking Status (please choose one):

- ☐ Current smoker
- ☐ Former smoker
- ☐ Never smoker

CURRENT MEDICAL CONDITION

Explain your foot/ankle problem: _____

When did problem begin? Date, if possible:_____

Has Condition been treated? _____ If so, When and how? _____

What is your shoe size? _____ Male Female Child *(circle appropriate answers)*

HIPAA COMPLIANCE

May we leave a voicemail with your lab/testing results, appointment reminders, and surgical dates?

Yes or No *(please circle)*

Who do you allow us to share your health information & items listed above with if you are unavailable?

Name & Number: _____ Relationship: _____

Name & Number: _____ Relationship: _____

Name & Number: _____ Relationship: _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided the opportunity to see a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read if I so chose) and understood the Notice.

_____ _____

Signature of Patient or Guardian/POA ***Date***

Please print your name: _____

Haag Foot & Ankle, PLLC

Dr. Cheryl Haag, Dr. Kevin Haag & Dr. Lester Haag

Specializing in Diseases & Surgery of the Foot & Ankle

4957 Swinyar Dr. Suite 105, Ooltewah, TN 37363 423-396-3668 FAX 423-396-2436

ASSIGNMENT OF BENEFITS AND FINANCIAL AGREEMENT

My signature at the bottom of this form authorizes payment for services rendered to myself or my dependent to be made directly to *Haag Foot & Ankle, hereafter referred to as "the office"*. This authorization is valid until I notify *the office* in writing that it is revoked but will not apply to services already rendered.

I understand that I am responsible for giving *the office* the correct insurance information before services are rendered and to update that information when it changes. *The office* agrees to bill my primary insurance carrier. If payment is not received from my insurance, I understand that the balance will become my responsibility. All insurance information must be provided to *the office* before services are rendered.

I understand that I am responsible for obtaining the proper referral and may be held responsible for charges not covered by my insurance due to my failure to obtain the required information.

I agree to pay for non-covered services under my insurance plan (services for which I have a policy exclusion). I understand that all co-pays are to be paid at the time services are rendered.

I understand that *the office* is not responsible for knowing if the group/physician is a participating provider with my insurance carrier, or is considered "in network".

T*he office* will expect all claims that are made patient responsible to be paid by the receipt of the first two statements. If my account has not been settled either by payment in full or by contacting the billing department to set up a payment plan, I will be charged a $10 re-billing fee, for each following statement. If I have made payment arrangements with *the office*, I will not be charged the re-billing fee. I understand my account will be turned over to collections if I do not fulfill the terms of my payment plan.

I understand that there is a $25 fee for all returned checks.

I also understand that if I do not call or cancel my appointment at least 24 hours prior, there will be a $25 missed appointment fee applied to my account. This fee may increase at *the office's* discretion.

I agree to show up to all my scheduled appointments on time and understand that if I come late, the appointment may need to be rescheduled to be fair to all patients.

I understand that I am responsible for all balances not paid by my insurance carrier, including deductibles, co-pays, coinsurance and out of network penalties. I further understand that if this balance is turned over to an outside collection agency, I shall be liable for all costs of collection, attorney fees, and court costs incurred by *the office*.

_____ _____

Signature of Patient or Guardian/POA ***Date***

Please print your name: _____