NORMAN/ EDMOND FOOT & ANKLE CLINIC
Dr. A Bil Buksh

PERSONAL INFORMATION: Date: _____

(Mr. / Mrs. / Ms. / Miss)
Patient Name: _____ (Last) _____ (First) _____ (M.I.) Nickname: _____

Age: _____ Date of Birth: _____ Gender: M / F Social Security#: _____

Address: _____
(Street) (City) (State) (Zip)

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Married Single Widowed Divorced Partnered E-Mail: _____

* The following two (2) questions are required by the government: Race: _____ Ethnicity: _____

Emergency Contact: _____ Phone: _____ Relation to patient: _____

Primary Care Physician: _____ **Last Visit:** _____

RESPONSIBLE PARTY: ___Self __ Parent/Legal Guardian

Name: _____ (Last) _____ (First) _____ (M.I.) Employer: _____

Date of Birth: _____ Social Security: _____ Relation: _____

INSURANCE INFORMATION:	**PRIMARY**	**SECONDARY**
Name of Company		
Employer		
Policy Holder Name		
Policy Holder Date of Birth		

I authorize treatment and diagnostic procedures to be performed by physician and by members of the staff. I authorize Norman/Edmond Foot & Ankle Clinic PC to furnish my insurance company, Medicare, referring physician, or other professional agencies who are concerned with my health and welfare, with all the necessary information regarding my present illness/injury. A photocopy or scan of this authorization shall be considered as effective and valid as the original. I certify that all information contained on this form is true and correct to the best of my knowledge. **I UNDERSTAND THAT A $25.00 CANCELLATION FEE MAY BE CHARGED FOR MISSED OR CANCELLED APPOINTMENTS UNLESS A TWENTY-FOUR (24) HOUR NOTICE IS GIVEN.**

_____ Patient or Parent/Legal Guardian Signature

_____ Relation to Patient

_____ Date

The following information will not be reviewed until you see the physician.

Current Weight _____ Height: _____ Shoe Size: _____

Reason for today's visit: _____

_____

Is it a result of an auto accident or workman's compensation? _☐_yes _☐_no

Date symptoms began: _____ Symptoms worsening over time? _____

Have you been treated for this condition in the past? (If yes, by whom?) _____

Other foot/ankle problems you would like to discuss with the Doctor?

☐ Ankle Instability	☐ Foot Pain	☐ Ingrown Nail	☐ Night Pain
☐ Ankle Pain	☐ Foot Swelling	☐ Leg Pain	☐ Numbness in Feet
☐ Ankle Swelling	☐ Hammer Toe	☐ Leg Cramping	☐ Toe Pain
☐ Bunion	☐ Heel Pain	☐ Nail Discoloration	

Are you or might you be pregnant? _____

MEDICATIONS: (prescriptions, over-the-counter medications, and supplements): (List dosage and frequency)

_____

_____

_____

_____

_____

ALLERGIES: (i.e., iodine, latex, antibiotics, pain medications, tape, etc.): (List reactions to medication)

_____

_____

Have you received the current flu vaccination _☐_**yes** _☐_**no**

If no, what is the reason? _____

<u>Patients 65 years of age and older:</u> Do you have a living will? _☐_**yes** _☐_**no**

Have you had a pneumonia vaccination? _☐_**yes** _☐_**no**

<u>PHARMACY:</u> _____ (Name) _____ (Location) _____ (Phone#)

PATIENT MEDICAL HISTORY

Description of previous foot/ankle treatments (i.e., over counter pads, braces, injections, etc.):

_____

_____

Have you ever been treated for or experienced any of the following illnesses? (Check all that apply)

- ☐ Anemia
- ☐ Arthritis (Osteo., RA, Other)
- ☐ Asthma
- ☐ Big Scars/Keloid
- ☐ Bleeding Disorders
- ☐ Calf Cramps (Walking/Night)
- ☐ Cancer (Type: _____)
- ☐ Chest Pain
- ☐ Circulation Problems
- ☐ Cold Fingers/Toes
- ☐ Diabetes (☐ I or ☐ II)
- ☐ Easy Bruising
- ☐ Epilepsy/Seizures
- ☐ Eye Problems
- ☐ Fibromyalgia
- ☐ Gout
- ☐ Heart Attack
- ☐ Heart Disease
- ☐ Heart Valves/Pacemaker
- ☐ Hepatitis (Type)
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Hip Pain
- ☐ Immunodeficiency (HIV)
- ☐ Joint Replacement
- ☐ Kidney Disease
- ☐ Knee Pain
- ☐ Liver Disease
- ☐ Lower Back Pain
- ☐ Neurologic Problems
- ☐ Phlebitis/Blood Clots
- ☐ Rheumatic Fever
- ☐ Sciatica
- ☐ Shortness of Breath
- ☐ Skin Rash
- ☐ Stomach/Bowel Problem
- ☐ Stroke
- ☐ TB
- ☐ Thyroid Problems
- ☐ Ulcer (Stomach or skin)

Please comment on any illness checked above or write in other conditions not listed:

_____

_____

PREVIOUS HOSPITALIZATIONS AND/OR SURGERIES (Please note date & any complications):

_____

_____

_____

SOCIAL HISTORY

☐ Alcohol Use If yes, select amount: ☐ 1-6 ☐ 7-12 ☐ 13-18 ☐ 19+ drinks per week

☐ Tobacco Use If yes, check frequency: ☐ Current (every day), ☐ Social (some days), ☐ Former Smoker
Number of Years

☐ Recreational Drug Use

FAMILY HISTORY List what family member has/had it

- ☐ Bleeding Disorders
- ☐ Cancer (Type ___)
- ☐ Cardiac Disease
- ☐ Diabetes (Type I or II)
- ☐ Liver Disease
- ☐ Respiratory Disease

Whom may we thank for referring you? _____

If not referred, how did you hear about our practice? _____

NORMAN/EDMOND FOOT & ANKLE CLINIC, PC

Financial Policy

Thank you for choosing Norman/Edmond Foot & Ankle Clinic, PC for your Podiatry needs. Our primary goal is rendering the best care available; therefore, if you have any questions regarding this Financial Policy, please contact our Billing Department at (405) 844-5052 (Monday-Friday8:00am-4:00pm)

PATIENTS WITHOUT INSURANCE: FULL Payment is due at the time services are rendered.

Insured Patient: Co-Payments, Deductible and/or Co-Insurance amounts are due at the time of service. Payment

Options: Visa, Discover, MasterCard, American Express, Money Order, Care Credit. All returned checks will accrue

a $25.00 return fee added to the account balance

Patients with large balances ($500.00 or more) will be expected to make a minimum payment equal or greater that 1/4 of total amount due. The balance should be **paid in** full within **(4)** months from the date of the agreement. Failure to comply with this arrangement will result in further collection activity.

Patients with balances less than $500.00 will be expected to make minimum payments equal or greater than 1/3 of the total amount due. The balance should be paid in run within (3) months from tile date of agreement. Failure to comply with this arrangement will result in further collection activity.

Delinquent accounts will be turned to the outside collection agency of our choice. Accounts are considered delinquent if unpaid after 60 days from due date. In the event your account is turned to collections, you will be required to pay this outstanding balance in full to the collection agency prior to initiating treatment with our physician. Delinquent accounts are subject to dismissal.

Privacy Policy

I understand that as a part of my health and medical care, this office originates and maintains medical and health records describing my health history, symptoms, examination and test results, diagnosis, treatment, and any plans for future care of treatment. I further understand that the information serves as:

- A basis for planning my care and treatment
- A means of communication among the health professionals who contribute to my care
- A source of information for applying my diagnosis and treatment information to my bill
- A means for third-party payer to verify that services were billed as actually provided

A copy of the PATIENT PRIVACY NOTICE is available to me to provide a more complete description of information uses and disclosures. I understood that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payments, or healthcare operations and that my physician is not required to agree to the restriction requested. I understand that I must revoke this consent in writing, except to the extent the organization as already acted. I agree and consent to the performance or diagnostic and therapeutic procedures deemed reasonably necessary by the physician. I acknowledge that there are no guarantees, expressed or implied as to the results of any procedures or medical treatment. I further understand my physician may order tests according to his/her judgment that may not be covered by my insurance carrier/third party payer although the physician and staff will attempt to arrange testing and consultation with providers in accordance with carrier/third party.

By Oklahoma Law we are required to notify you that the information authorized for release may include records which may indicate the presence of a communicable or venereal disease which may include but not limited to, diseases such as hepatitis, syphilis, gonorrhea, aids, and mental health.

I request the following restrictions to the use and/or disclose of my health information

I wish to be contacted in the following manner:

Telephone

Cell Telephone: (__)_____
☐ Leave Message
☐ No message, leave call-back number
☐ Text

Work Telephone: (___)_____
☐ Leave Message
☐ No message, leave call-back number

Written

☐ OK to mail to home address
☐ OK to mail to my work/office

Name and relationship of person we can speak to regarding your health information

_____(Name, phone number)

_____(relationship)

I have read and understand the financial and privacy policy for Norman/Edmond Foot & Ankle Clinic, PC.

(Patient or Legal Guardian Signature) (Relation to Patient) (Date)

E-PRESCRIBING CONSENT FORM

ePrescribing is defined by a Physician's ability to electronically send an accurate, error free and understandable prescription directly to a pharmacy. Congress has determined that the ability to electronically send prescriptions is a crucial element in improving the quality of patient care. ePrescribing reduces medication errors and enhances patient safety. The Medicare Modernization Act (MMA) 2003 listed standards that must be included in an ePrescribe program.

These include:

Formulary and benefit transactions - gives the prescriber information about which drugs are covered by the drug benefit plan.

Medication history transactions - provides the physician with information about medications the patient is already taking to minimize the number of adverse drug events.

By signing this consent form, you are agreeing that [Dr. Buksh's office] can request and use your prescription medication history from other healthcare providers and/or third-party pharmacy benefit payors for treatment purposes.

Understanding all the above, I hereby provide informed consent to [Dr. Buksh's office] to enroll me in the ePrescribe program. I have had the chance to ask questions and all my questions have been answered to my satisfaction.

This consent will remain enforce until revoked or changed.

Patient Name (PLEASE PRINT)_____

Signature _____ Date _____

Relationship to Patient: _____

Pharmacy (Name & Location) _____