University Foot Center, Inc.

Podiatric Medicine and Surgery
Steventon S. Wagner, DPM, DABPS, FACFAS
Lynette R. Mehl, DPM, AACFAS

Name_____ ***Date of Birth***_____***Date***_____
Height _____***Weight*** _____ Shoe Size_____Shoe Type _____

Reason for Today's Visit_____
_____
_____

- ***Circle any Other Conditions*** Bunions-Hammertoes-Ingrown deformed toenails Heel/arch pain-Bone Spur -Tendon pain-Nerve pain-Growth-Warts-Infection-Swelling-Dry skin-Athlete's foot-Wound-General pain-Cramping-Arthritis

History of Your Problem_____
Location on your foot/ankle _____
Injury?_____ If so, where did it happen ?_____
Duration of problem_____ Onset (Sudden or Gradual)
Rate Your Pain 0-10_____ Constant or Sometimes, When?_____
Aggravating Factors_____
Treatment to date (You or another Physician)_____
_____
Does this restrict any activities?_____

Your Medical History_____
_____
_____
_____

Surgeries_____
_____

Medications_____
_____

Drug Allergies_____

Social History
Marital Status_____ Children_____ Do you live with anyone?_____
Alcohol use_____ Tobacco use_____

Family Medical History_____

Activities, sports, interests hobbies_____
_____ ***Initials***_____

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Patient's Name_____Date of Birth_____
Policy Holder's Name_____ Date of Birth_____
Address_____ City_____ State_____ Zip_____
Phone Home ( )_____Cell ( )_____Work ( )_____
Social Security #_____ Gender_____ Occupation_____
Email _____ Employer_____
Emergency Contact_____Phone ( )_____

Referred By_____ Spouse/Other_____
Primary Care Doctor_____ Date of Last Visit _____

Consent for Care and Information Release

I request care and authorize University foot Center, Inc. and associates to provide service, obtain history, physical exam and other information. I consent to treatment as necessary in the diagnosis and treatment of my foot/ankle condition.

I authorize University foot Center, Inc. and associates to use my health information for my care, insurance billing purposes and records acquisitions in accordance with Federal Law.

I authorize University foot Center, Inc. and associates to bill my insurance with payment directly to University foot Center, Inc. and associates for time and services rendered. I understand that my choice of insurance coverage and its terms are between myself and my carrier. University foot Center Inc. and associates will assist me with my insurance but I understand it is my obligation to be aware of my carrier's rules, determine if the physician is a provider for my insurance, and I am ultimately responsible for any necessary referrals or prior authorization. I understand I am personally responsible for any charges as a result of my evaluation, diagnosis, treatment and care including balances, deductibles and co-pays. Unpaid balances are my responsibility and I authorize the use of a collections agency if unpaid.

Any change to my health information, address, contact information, or insurance is my responsibility and I will notify and update University foot Center Inc. immediately.

I consent to the use of my cell phone and email for contact and scheduling purposes. All of my questions regarding these policies have been answered.

Initials_____

Patient Privacy, Patient Rights and Protected Health Information Notice

In accordance with the Federal HIPAA act of 1996 I had the opportunity to read the notice and that a copy was available to me. I understand my patient rights and how my health information may be used during normal healthcare operations. I understand that my health information will not be disclosed for any other reason other than healthcare and billing purposes without my consent.

Initials_____

Patient or Authorized/ Guardian Name_____
Signature _____Date_____