CAROLINA Foot&Ankle SPECIALISTS

❑ Dr. Adam C. Brown, DPM
West Ashley | 615 Wesley Drive, Suite 340
Charleston, SC 29407 | Phone 843-225-5575

❑ Dr. Andrew D. Saffer, DPM
Mt. Pleasant | 501 Bramson Court, Suite 301
Mt. Pleasant, SC 29464 | Phone 843-654-8250
(Across from Belle Hall Shopping Ctr on Longpoint Rd.)

PATIENT INFORMATION

Patient Name: _____ Preferred Name: _____

❑ MALE ❑ FEMALE DOB: _____ /_____ /_____ Age: _____ Social Security No: _____-_____-_____

Address: _____

Mailing Address (if different from above): _____

City:_____State:_____Zip:_____

Home Phone:_____Work Phone:_____Cell Phone:_____

Email:_____

Race: ❑ American Indian or Alaska Native ❑ Asian ❑ Black or African American ❑ White ❑ Other_____

Ethnicity: ❑ Hispanic or Latino ❑ Not Hispanic or Latino

Primary Language: _____

Marital Status: ❑ Single ❑ Married ❑ Partner ❑ Legally Separated ❑ Divorced ❑ Widowed ❑ Unknown

Employer:_____Occupation:_____

Emergency Contact Name and Phone #:_____

Primary Care Physician: _____ Date last seen: _____

Referred by: ❑ Dr. ❑ Mr. ❑ Mrs. _____ ❑ Insurance Co. ❑ Internet ❑ Yellow Pages

Primary Insurance:

Insurance Company:_____

Policy Holder Name: _____

Policy Holder Date of Birth: _____

Policy Holder SSN:_____–_____–_____

Secondary Insurance:

Insurance Company:_____

Policy Holder Name: _____

Policy Holder Date of Birth: _____

Policy Holder SSN:_____–_____–_____

Guarantor/Financially Responsible Person (if different from patient)

Name: _____ Date of Birth: _____ SSN:_____-_____-_____

Phone Number: _____ Relationship to patient: _____

May we leave a voice message to remind you about appointments at the phone numbers you provided? ❑ YES ❑ NO

May we leave a voice message for normal test results at the phone numbers you provided? ❑ YES ❑ NO

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Patient Name_____

MEDICAL INFORMATION

Reason for this visit_____

Length of time for current problem_____ ❑ Days ❑ Weeks ❑ Months ❑ Years

Height _____feet _____inches / Weight_____pounds

Do you smoke? (check one) ❑ Yes** ❑ No **If yes ❑ Heavy or ❑ Light

Do you drink alcohol? (check one) ❑ Yes** ❑ No **If yes ❑ Occasionally or ❑ Light/Moderate

Have you received a flu vaccination for the current season? ❑ Yes ❑ No

For those 65 or older, have you had a pneumonia vaccine? ❑ Yes ❑ No

CURRENT MEDICATION LIST

❑ No Medications ❑ Yes, please see below

_____ _____ _____ _____

_____ _____ _____ _____

MEDICAL ALLERGIES

❑ No Known Allergies	❑ General Anesthestics	❑ Local Anesthestics	❑ Other_____
❑ Aspirin	❑ Iodine	❑ Penicillin	❑ Other_____
❑ Codeine	❑ Latex	❑ Sulfa	❑ Other_____

PAST MEDICAL HISTORY

❑ Angina	❑ Diabetes	❑ Kidney Problems	❑ Other_____
❑ Asthma	❑ Heart Disease	❑ Poor Circulation	❑ Other_____
❑ Cancer	❑ High Blood Pressure	❑ Stomach Problems	❑ Other_____
❑ Depression	❑ High Cholesterol	❑ Thryoid Problems	❑ Other_____

FAMILY HISTORY

Check ❑ Mother or ❑ Father if applicable

	M F		M F		M F
❑ Cancer	❑ ❑	❑ High Blood Pressure	❑ ❑	❑ Other_____	❑ ❑
❑ Diabetes	❑ ❑	❑ High Cholesterol	❑ ❑	❑ Other_____	❑ ❑
❑ Heart Disease	❑ ❑		❑ ❑	❑ Other_____	❑ ❑

PREVIOUS SURGERIES

_____ _____

❑ For those 65 or older, do you have a living will or someone to make decisions on your behalf? ❑ Yes ❑ No

If no, please state why._____

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Ongoing Communication Regarding Your Healthcare

DO YOU WANT TO DESIGNATE A FAMILY MEMBER OR OTHER INDIVIDUAL WITH WHOM THE PROVIDER MAY DISCUSS YOUR MEDICAL CONDITIONS? IF YES, WHOM? (Please provide the information below.)

For ongoing communication regarding your healthcare and for your privacy, you must complete this section to authorize this Practice to release and/or discuss your health information with the following people or organizations for the following specific dates of service. Any revocation or modification to your authorization with regard to a family member or other individual must be submitted in writing.

From date of service:_____ To date of service:_____

Name of Person	Address	Phone/Fax	Relationship to you

A separate Authorization to Release Information Form must be completed for other releases and disclosures not listed in the section above.
To request restrictions of the use of your information, you must complete a separate Request for Restrictions Form.

Authorization, Assignment of Benefits, and Referral Medical Release

I consent to treatment and allow this Practice and their affiliates to use and release my protected health information for treatment, payment, and healthcare operations as allowed by HIPAA and as described in the Notice of Information Practices, of which a copy has been made available to me.

I understand that my medical information including complete medical records, test results, and billing information may be released to my insurance company and to other medical professionals and/or medical care institutions for treatment and payment purposes.

I allow payment to be made directly to Carolina Foot Specialists for all medical or surgical benefits otherwise payable to me under terms of my insurance.

I understand that I am financially responsible for paying all co-payments, co-insurance, deductibles, and non-covered services.

I authorize the use of this signature on all insurance submissions.

A photocopy of this form shall be considered as effective and as valid as the original.

To the best of my knowledge the information I have given on this form is accurate and true. I know it is my or my legal guardian's responsibility to keep this Practice and my Physician informed of changes to any of my contact information; a failure to do so may interfere with the ability to contact me concerning my healthcare.

Patient's Signature: _____ Date: _____

Print Patient's Name: _____

Legal Guardian's Signature:_____ Date: _____

Print Legal Guardian's Name:_____

Office Use Only: