SOHL FOOT & ANKLE
MEDICAL & SURGICAL PODIATRY

WELCOME TO OUR OFFICE!

Please print and complete the following information for your case history file.

Patient's Last Name:		First Name:		Middle Initial:	Preferred Name:
Date of Birth:	Age:	Gender: ☐ Male ☐ Female ☐ Undifferentiated		Spouse/Guardian Name:	
Residence Street Address:		City:		State:	Zip Code:
Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Partnered ☐ Divorced			Social Security #:		How did you find this office?
Race: ☐ Native American/Alaskan ☐ Pacific Islander ☐ African Descent ☐ Asian Descent ☐ White/European Decent ☐ Middle Eastern Decent ☐ Decline ☐ Other:			Ethnicity: ☐ Hispanic ☐ Non-Hispanic ☐ Decline ☐ Other:		Preferred Language: Preferred Music Genre:
Home Phone:	Cell Phone:	Work Phone:		Email:	
Occupation Status: ☐ Employed ☐ Unemployed ☐ Retired ☐ Disability ☐ Student ☐ Child			Physical Activities: ☐ Work ☐ Walking ☐ Running ☐ Gym ☐ Cross Fit ☐ Sports ☐ None		
Employer/School:			Job Title:		
Preferred Contact Method: ☐ Phone ☐ Text ☐ Email ☐ Mail		Emergency Contact Name/Phone/Address			Relationship
Healthcare power of attorney? ☐Y ☐N Living Will? ☐Y ☐N		Name of Healthcare Power of Attorney:			Relationship:
Primary Insurance Plan: ID #:			Secondary Insurance Plan: ID #:		
Card Holder Name if not Self: Date of Birth:			Card Holder Name if not Self: Date of Birth:		
Name of Primary Healthcare Doctor:	Primary Care Address:			Zip Code	Phone Number:
Pharmacy Name:	Pharmacy Address:			Zip Code*	Phone Number:
Permission to download Medication history: ☐Y ☐N	Permission to add/save images to your medical record: ☐Y ☐N				

I hereby give Dr. Sohl permission to examine and treat my feet, ankles, and related health issues. I authorize use of these forms on all my insurance submissions. I authorize release of information to all my insurance companies. I understand that I am responsible for my bill. I authorize my doctor to act as my agent in helping me obtain payment from my insurance companies. I authorize direct payment to my doctor. I permit a copy of this authorization to be used in place of the original.

Signature Relationship if Guardian Status Date

SOHL FOOT & ANKLE
MEDICAL & SURGICAL PODIATRY

INITIAL CLINICAL HISTORY FORM

Name:			Date of Birth:	
Height:	Weight:	Shoe Size:	Preferred Shoe Type?	Do you wear inserts/orthotics? ☐ Yes ☐ No
What is your chief foot, ankle or leg complaint?				Which side? ☐ Right ☐ Left ☐ Both
Is there pain? ☐ Mild ☐ Moderate ☐ Severe			How long has this problem existed?	
How did it happen? ☐ Injury ☐ Gradual ☐ Recurrent ☐ Chronic ☐ Overuse				What treatment have you had?
Describe pain: ☐ Ache ☐ Burn ☐ Throb ☐ Gnawing ☐ Radiating ☐ Electric ☐ Other:			What makes it better?	What makes it worse?

Review of Systems:

Constitution	**Y / N**
Chills	☐ ☐
Fatigue	☐ ☐
Fever	☐ ☐
Weakness	☐ ☐
Weight Gain or Loss	☐ ☐
Other?	

Ears/Nose/Throat	**Y / N**
Dry Mouth	☐ ☐
Ear Ringing	☐ ☐
Hearing Loss or Aide	☐ ☐
Nose Bleeds	☐ ☐
Sore Throat or Hoarse	☐ ☐
Other?	

Respiratory	**Y / N**
Blood in Sputum	☐ ☐
Chronic Cough	☐ ☐
Productive Cough	☐ ☐
Shortness of Breath	☐ ☐
Wheezing	☐ ☐
Other?	

Cardiovascular	**Y / N**
Blood Clots	☐ ☐
Chest Pain	☐ ☐
Cool Extremities	☐ ☐
Heart Palpitations	☐ ☐
Leg Cramps when Walking	☐ ☐
Other?	

Gastrointestinal	**Y / N**
Abdominal Cramps	☐ ☐
Constipation	☐ ☐
Diarrhea	☐ ☐
Heart Burn	☐ ☐
Nausea	☐ ☐
Other?	

Musculoskeletal	**Y / N**
Joint Pain	☐ ☐
Joint Stiffness	☐ ☐
Joint Redness	☐ ☐
Low Back or Buttock Pain	☐ ☐
Muscle Weakness	☐ ☐
Other?	

Psychiatric	**Y / N**
Anxiety	☐ ☐
Depression	☐ ☐
Disorientation	☐ ☐
Insomnia	☐ ☐
Memory Loss	☐ ☐
Other?	

Skin	**Y / N**
Dry or Itchy Patches	☐ ☐
Infections	☐ ☐
Rash	☐ ☐
Warts	☐ ☐
Wounds	☐ ☐
Other?	

Neurologic	**Y / N**
Numbness/Tingling	☐ ☐
Radiating Pain or Burning	☐ ☐
Seizures	☐ ☐
Unsteady Gait	☐ ☐
Weakness	☐ ☐
Other?	

Endocrine	**Y / N**
Excessive Sweating	☐ ☐
Hot or Cold Intolerance	☐ ☐
Increased Thirst	☐ ☐
Increased Appetite	☐ ☐
Increased Urination	☐ ☐
Other?	

Hematologic	**Y / N**
Anemia	☐ ☐
Blood Clots	☐ ☐
Bleeding Issues	☐ ☐
Bruise Easily	☐ ☐
Swollen Glands	☐ ☐
Other?	

Allergic/immunologic	**Y / N**
Hives	☐ ☐
Itchy Eyes or Nose	☐ ☐
Nasal Congestion	☐ ☐
Swelling	☐ ☐
Wheezing	☐ ☐
Other?	

Urinary	**Y / N**
Blood in Urine	☐ ☐
Burning	☐ ☐
Kidney Stones	☐ ☐
Incontinence	☐ ☐
Urgency	☐ ☐
Other?	

Male Genitalia	**Y / N**
Hernias	☐ ☐
Prostate Problems	☐ ☐
Female Genitalia	**Y / N**
Lower Abdomen Cramps	☐ ☐
Menopause	☐ ☐
Other?	

Eyes	**Y / N**
Blurred Vision	☐ ☐
Cataracts	☐ ☐
Glasses/Contacts	☐ ☐
Glaucoma	☐ ☐
Sties	☐ ☐
Other?	

Foot/Ankle/Leg History:

☐ Ingrown Toe Nails	☐ Fungal Nails	☐ Ankle Sprains	☐ Foot/Ankle Wounds	☐ Tripping
☐ Heel/Arch Pain	☐ Calluses	☐ Injury	☐ Punctures/Lacerations	☐ Toe Stubbing

Are you pregnant? ☐ Yes ☐ No Are you taking birth control? ☐ Yes ☐ No

Allergies: ☐ No known allergies ☐ Penicillins ☐ Sulfa ☐ Iodine ☐ Adhesive Tape ☐ Local Anesthetic

List other allergies/reactions: _____

_____

Medications: If you **did not** opt for medication list download permission, please list all current prescription medications, over-the-counter medications or vitamins, frequency and dosage.

Medication/Vitamin Name Route (oral vs injectable) Dosage Frequency(times per day)

_____

_____

_____

_____

_____

_____

_____

Related Family History: (Circle if applicable)

Family Member: _____Alive/Deceased?

Alcoholism	Bunions	Cancer
Diabetes	Gout	Heart Attack
Hypertension	Kidney Dz	Stroke

Other: _____

Family Member: _____Alive/Deceased?

Alcoholism	Bunions	Cancer
Diabetes	Gout	Heart Attack
Hypertension	Kidney Dz	Stroke

Other: _____

Past Medical History: (Circle if applicable)

Anemia	Anxiety	Arthritis	Asthma	Atrial Fibrillation
Autoimmune Dz	CAD	COPD	CVA	Charcot Foot
Cancer, Type:		Chronic Pain	Diabetes I or II	DVT
Depression	Diverticulitis	Foot Ulcers	Fibromyalgia	GERD
Gout	HIV or Hepatitis	Hypercholesterol	Hypertension	Hypothyroidism
Kidney Dz	MI(Heart Attack)	Opioid Dependency	Osteoporosis	PAD or PVD
Pneumonia	Peripheral Neuropathy	Rheumatism	Seizures	Varicose Veins

If you have **Diabetes**, what was your latest **A1c** result? ___% what month? _____ or "don't know"

List any other chronic illness not listed above:

_____

_____

Social History:

Tobacco Use: (check appropriate box)

☐ Current Tobacco Use? How many Years?	Have you attempted Smoking Cessation? ☐ Y ☐ N	☐ Former When did you stop?	☐ Never
☐ Cigarettes	☐ Cigars	☐ Pipe	☐ Chew/Dip

Alcohol Use: (check appropriate box)

☐ Social	☐ Occasional	☐ Light	☐ None
☐ Heavy	☐ Dependency	☐ In Recovery?	

☐ Beer
☐ Wine
☐ Liquor

Drug Use: (circle choice or check appropriate box)

Current or Former? Last Use?	☐ Dependent		☐ In Recovery?		☐ None
☐ Marijuana	☐ Opioids	☐ Hallucinogens	☐ Prescription Medications	☐ Cocaine	☐ Methamphetamines

Activity and Exercise: (check appropriate box)

Do you use and assistive walking device? ☐ None ☐ Cane ☐ Walker ☐ Brace ☐ CAM walker/boot

Please select any exercise activities that you regularly perform?

☐ Walking (miles/week:____) ☐ Running (miles/week:_____) ☐ Incline Treadmill or Hills (miles/week:_____)

☐ Stair Climber ☐ Cross Fit ☐ Gym ☐ Plyometric ☐ Yoga

Dwelling: (check appropriate box)

☐ Apartment/condo ☐ house ☐ mobile home ☐ retirement home ☐ assisted living ☐ homeless

Past Surgical History: Please list all surgeries; include year.

_____ _____

_____ _____

_____ _____

_____ _____

Attestation: I attest to the best of my knowledge that the information put forth on this medical history form is accurate. I understand that false or withheld information could lead to health risks or dangers. I understand that it is my responsibility to update the medical staff or doctor of any significant changes to my medical status.

Signature Relationship if Guardian Status Date

Consent to the Use and Disclosure of Health Information for Treatment, Payment, or Healthcare Operations

I understand that as a part of my healthcare, Sohl Foot & Ankle originates and maintains health records describing my health history, symptoms, examination and test results, diagnosis, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment
- A means of communication among many health professionals who contribute to my care
- A source of information for applying my diagnosis and surgical information to my bill
- A means by which a third-party payer can verify that services billed were actually provided
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand and have been provided with a ***Notice of Information Practices*** that provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. I understand that Sohl Foot & Ankle reserves the right to change their notice and practices and prior to implementation will mail a copy of any revised notice to the address I've provided. I understand that I have the right to object to the use of my health information for directory purposes. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that Sohl Foot & Ankle is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the practice has already taken actions in reliance thereon.

I will allow the disclosure of my health information to (designate person):_____

Permission to leave a message on my home telephone voicemail or answering machine:
yes_____ no_____

Signature of authorized representative or self:_____

Birthdate:_____ Date of Consent_____

This practice maintains patient sign in sheet that are visible and accessible to patients, staff, and others who may enter this office.

FINANCIAL POLICY

Thank you for choosing Sohl Foot & Ankle to serve you and your family's health needs. We are pleased to participate in your family's healthcare and look forward to establishing a lasting relationship as your primary health care provider. As part of this relationship, we wish to establish our expectations of your financial responsibility as outlined in our financial policy. **Your medical insurance is a contract between you and your insurance company. We can help with providing information to help you in filing claim, but you are primarily responsible for any charges that you have incurred as a patient with Sohl Foot & Ankle.** Please review and sign the following financial policy prior to your office visit.

1. CO-PAYMENTS, DEDUCTIBLES, AND FEES- **All co-payments, insurance deductibles, and fees for service not covered by your insurance policy are due at the time service is rendered.** We accept: CASH, CHECK, MONEY ORDER, or CREDIT CARDS.

2. INSURANCE- Patients must complete and sign information and insurance forms prior to seeing the physician. **You must present a current insurance card at each visit. If you or your children do not present a current insurance card, you will be responsible for payment at the time of your visit.** You will receive reimbursement from Sohl Foot & Ankle if your insurance pays the claim, at a later date. If your insurance carrier is not one with which we participate, you are responsible for payment in full. Insurance plans and Medicare considers some services to be "non-covered", in which case you are responsible for payment in full. According to NC Statute 58-22253, insurers are required to pay properly submitted claim within 30 days. You have a responsibility to provide information to our office so a claim can be properly submitted. **If your insurance company has not paid a claim on your behalf within 90 days because of information you have not provided, the balance will be transferred to your account and you will be responsible for payment.** If we receive payment at a later date you will be reimbursed by Sohl Foot & Ankle.

3. MINORS AND DEPENDENTS- Parents and guardians are responsible for payments for their dependents at the time the service is rendered. **Minors and dependents must present valid insurance card at each visit if a claim is to be filed.** See item #2 above if an insurance card is not presented.

4. MISSED APPOINTMENTS**- Unless they are cancelled at least 24 hrs. in advance, our policy is to charge for missed appointments.** The fee for a missed appointment is **$10**. This fee is not covered by your insurance plan and is your responsibility.

5. PROMPT PAYMENT- Just as we make every effort to accommodate you when you are in need of medical care, we expect that you will make every effort to pay your bill promptly. If you have financial hardship or if you are unable to pay your bill in its entirety, please contact our billing line to discuss payment options. ***There will be a 1.5 % late fee added per month on any account that is past due over 60 days.*** **If your account becomes delinquent and you have not established or made payment arrangements with our billing office, your account will be turned over to a collection agency. A collection fee of $75 will be added to account in addition to the 1.5% late fee. We may ask you to see you podiatric care from another podiatric office.**

I have read the financial policy and agree to its terms.

Patient Signature: Date signed: