Ahmad K. Elsamad, D.P.M., F.A.C.F.A.S.
Podiatrist Foot & Ankle Surgeon ABPS Board Certified
Fellow of American College of Foot & Ankle Surgeons—Diplomat of American Board of Foot & Ankle Surgery
The Institute of Foot & Ankle Reconstructive Surgery
9239 Broadway, Merrillville, IN 46410------9134 Columbia Ave., Suite B, Munster IN 46321
Phone: 219-736-1010 Fax:219736-1090

PATIENT INFORMATION

PATIENT DEMOGRAPHIC FORM

(THIS FORM IS TO BE UPDATED YEARLY OR WITH ANY INFORMATION CHANGES

Patient Name: _____ Patient's Social Security Number: _____
Date of Birth: _____ Age: _____ Gender: M __ F __ Marital Status: S __ M __ D __ W __
Language Preference if not English: _____ Other communication issues? N __ Y __ (what) _____
Race: Black/African American__ American Indian/Alaska Native__ Asian__ Native Hawaiian/Pacific Islander__
White__ Other_____ Don't Know__ Ethnicity: Hispanic/Latino___ Non-Hispanic/Latino___
Street Address: _____ Apt. No.: _____
City: _____ State _____ Zip Code: _____
Home phone: (_____) _____ Work phone: (_____) _____
Cell/Pager number: (_____) _____ Email Address: _____
Emergency Contact Name: _____ Emergency Contact Phone: (_____) _____

GUARANTOR/PARENT INFORMATION **[] Check here if Workers comp case**

Responsible Party Name: _____ _____ _____
(Last) (First) (Middle)
Relationship to Patient: _____ Responsible Party Date of Birth: _____
Guarantor's Social Security Number: _____ - _____ - _____
Guarantor's Address: _____ Apt. No.: _____
City: _____ State _____ Zip Code: _____
Home phone: (_____) _____ Cell/Pager number: (_____) _____
Employer's Name: _____ Work Phone: (_____) _____
Employer's Address: _____
City: _____ State _____ Zip Code: _____

PATIENT'S INSURANCE INFORMATION *Please provide Insurance Card and Photo ID to Receptionist

Primary Insurance Company's Name: _____
Name of Policy Holder: _____Date of Birth: _____
Insurance ID Number: _____ Group Number: _____

Secondary Insurance Company's Name: _____
Name of Policy Holder: _____Date of Birth: _____
Insurance ID Number: _____ Group Number: _____

PATIENT'S PHARMACY INFORMATION

PHARMACY NAME _____ LOCATION/CITY_____ PHONE NUMBER_____

*****PATIENT'S REFERRAL INFORMATION*****

Primary Care Physician _____ Phone (_____) _____

Referral Source _____ Phone (_____) _____

Please Read and Sign Both Sides of this Form: hereby authorize my insurance benefits to be paid directly to Ahmad K. Elsamad, DPM. I understand and am responsible for all charges including my added costs incurred due any effort to collect for services rendered. I realize I am responsible to pay for non-covered services and I hereby authorize the release of pertinent medical information to insurance carriers.

Signature of Responsible Party: _____ Date: _____

MEDICAL HISTORY

General History

Full Name: _____ Date of Birth: _____Age:_____ Occupation: _____
Weight: _____ Height: _____ Shoe Size: _____ Family Doctor: _____ Last Seen: _____
Related to: Work: *Yes/ No/ Maybe Auto: *Yes/ No/ Maybe Accident: *Yes/ No/ Maybe Are you pregnant? Yes/ No/ Maybe
Smoking: Packs/day: _____ Years: _____ Past Smoker: Packs/day _____ Years: _____
Alcohol: Quantity _____ None Rarely Moderately Daily Quit
Recreational Drug Use: None Moderately Daily Quit
List Athletic activities: _____ Amount per day/week: _____
Have you ever been to a Podiatrist before: Yes/No. If yes, please list. Name: _____ Last Seen: _____
Have you ever worn orthotics/arch supports? Yes/No. If yes, what kind: _____

History Of: Do you have or have you ever been treated for: (circled items to indicate YES)

AIDS/HIV	Bunions	Fibromyalgia	Low Blood Pressure	Special Diet
Anemia	Chest Pain	Flat Feet	Lung Disease	Sports Related Injuries
Angina	Chemical Dependency	Gout	Nervous Problems	Stomach Ulcers
Ankle Pain	Cancer	Headaches	Osteoporosis	Stroke
Arthritis	Circulatory Problems	Heart Disease	Phlebitis	Swelling in
Artificial Heart Valves	Corns and Calluses	Heel Pain	Plantar Warts	Tired Feet
Artificial Joints	Depression	Hemophilia	Radiation Treatment	Thyroid Disorder
Asthma	Diabetes	High Blood	Rash	Tuberculosis
Athlete's Foot	Ear Problems	Ingrown Toenails	Rheumatic Fever	Varicose Veins
Back Problems	Eye Problems	Kidney Problems	Seizure Disorders	Venereal Disease
Bleeding Disorders	Fainting	Liver Disease	Sinus Problems	Weight Loss,

Family History

List Relationship to you of family members who have had: Foot Problems: _____
Arthritis: _____ Diabetes: _____ Heart Problems: _____

Past Surgical Procedures/other Hospitalization:

Surgical History _____Date _____Hospitalization History Date

_____ _____ _____ _____

_____ _____ _____ _____

Previous Blood Transfusions: Yes/ No Exposure to Hepatitis: Yes/ No

Allergies

Are you allergic to any of the following: (circle what applies and note any reactions) or CIRCLE: **No Known Allergies**

Adhesive/Tape: _____ Anticoagulants: _____ Aspirin: _____
Codeine: _____ Demerol: _____ Iodine: _____
Local Anesthetics: _____ Novocain: _____ Penicillin: _____
Seafood: _____ Sulfa: _____ Other: _____

I hereby give permission to Dr. Ahmad ElSamad to administer treatment and perform such procedures as may be deemed necessary in the diagnosis and/or treatment of the extremity condition. I also hereby assign to the above named physicians all benefits provided by my insurance company policy or policies for medical or surgical care. I understand that I am financially responsible for any balance due on my account. 0 00

Print Patient's Name: _____ Signature of Patient/Guardian: _____ Date: _____

NEW VISIT PATIENT INFORMATION

Name_____ Date_____

Current Medications
(please attach additional list if they apply)

Include prescriptions, over-the-counter medications and vitamins: _____
_____
_____

Please list up to 3 areas of concern you would like to discuss during your visit with the doctor.

Workers comp case
DATE OF INJURY _____

1._____
2._____
3._____

Most of my pain is in the: (please circle one) **right—left — both. Location**: (circle all that apply) **right——left—both— foot —ankle —leg**
Nature of pain: (please circle) **aching——throbbing—sharp—shooting—burning—electrical—radiating**
Duration How long have you had this problem? _____**days—months—years does your pain limit your activities?** _____days per week.
Current pain level: (please circle one) (*least* pain) **0 1 2 3 4 5 6 7 8 9 10** (*most* pain)
Onset: (circle all that apply) **came on suddenly——came on gradually—off and on**
Course: (circle all that apply) **getting worse——staying the same—getting better— comes and goes**
Aggravation: My pain is worse when: (please circle one) **I step out of bed— when active— resting—at night. What makes it better:** _____

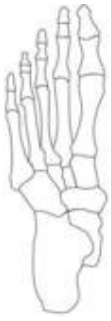
Have you had any of the following health tests performed within the ***last year***?

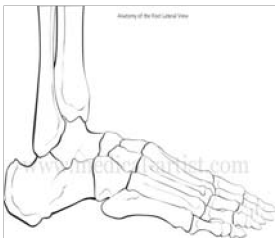
Blood work	Yes / No
Foot X-ray	Yes / No
Ankle X-ray	Yes /No
Vascular Testing	Yes / No
MRI of Foot	Yes / No
CT Scan of Foot	Yes / No
Doppler Study	Yes / No
Other _____	

If yes, what test was performed and where was it performed including blood work.
_____
_____

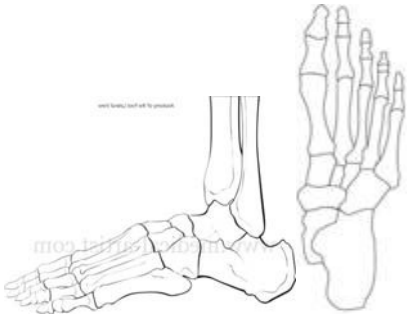
Please use circles and arrows to indicate painful, injured or problem area(s)

LEFT





RIGHT



Ahmad K. Elsamad, DPM, FACFAS

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PATIENT ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION

This Notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

This office is required by federal regulation, known as the HIPAA Privacy Rule, to maintain the privacy of your health information and to provide you with notice of its legal duties and privacy practices. This office will not use or disclose your health information except as described in this Notice.

This office is permitted by federal privacy laws to make uses and disclosures of your health information for purposes of treatment, payment, and health care options. Protected health information is the information we create and obtain in providing our services to you. The health information about you is documented in a medical record and on a computer. Such information may include documenting your symptoms, medical history, examination, test results, diagnoses, treatment, and applying for future care of treatment. It also includes billing documents for those services.

There may be times that interns or students will be present in the office, either in patient rooms or in a clerical position. If you do not wish for the student to be present or that they are not allowed to access your private health information, please let us know. We will make every effort to accommodate your wishes.

I will have the opportunity to review the HIPAA Privacy Rule Kit at any time, which is available to me in the office.

Patient's Name: _____ Date: _____
Patient/Parent/Guardian Signature: _____

IMPORTANT OFFICE POLICIES

RELEASE OF MEDICAL INFORMATION

I authorize The Institute of Foot & Ankle Reconstructive Surgery. to release the medical records concerning my son/daughter/self to any physician, hospital, or agency involved in the care of the patient listed.

ASSIGNMENT OF MEDICAL BENEFITS

I authorize my insurance carrier to assign all surgical and or medical benefits, if applicable, to The Institute of Foot & Ankle Reconstructive Surgery. I also authorize release of medical information necessary to process all medical insurance claims.

PAYMENT POLICY

Co-payments are to be collected at the time services are received. We accept cash and checks. All medical services provided are directly charged to the patient or responsible party. If our physician is contracted with your insurance carrier, we will accept their negotiated rate for the charges billed. Payment is expected in full upon receipt of statement or payment arrangements must be made with our billing office. I understand that I am financially responsible for ALL charges whether paid by insurance or not. I agree to pay the full/entire amount of any services provided. I understand that accounts over 60 days are considered delinquent. I understand that a fee of 1.8% of the amount due will be added if my account is turned over to a collection agency. I understand that I will be responsible for all court costs and attorney fees if my account is sent to collections.

CANCELLATION POLICY

Our office requests that if an appointment needs to be cancelled that we receive notice no later than 4 hours prior to the appointment. We reserve the right to charge $50.00 for a “no show” appointment, to be collected on or before your next appointment.

REFERRAL POLICY

I understand that it is my responsibility to obtain a referral through my primary care physician’s office if required by my insurance company. Failure to do so will result in charges being billed directly to myself.

I HAVE READ, UNDERSTAND, AND AGREE TO ABIDE BY THE ABOVE RELEASE OF MEDICAL INFORMATION, PAYMENT, AND OTHER OFFICE POLICIES.

Signature of Responsible Party: _____ Date: _____