

Account #: \_\_\_\_\_  
(office use only)

Patient Information Sheet

Southern Ohio Foot and Ankle Associates, Inc.  
John F. Boyle, D.P.M.

1130 Western Avenue  
Chillicothe, Ohio 45601

1235 South Court Street  
Circleville, Ohio 43113

Patient Name \_\_\_\_\_ Date \_\_\_\_\_  
Last First MI

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Telephone (\_\_\_\_) \_\_\_\_\_ Cell Phone (\_\_\_\_) \_\_\_\_\_ Work Phone (\_\_\_\_) \_\_\_\_\_

Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Sex ( ) Male ( ) Female Social Security # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Marital Status ( ) Married ( ) Single ( ) Other

Are You a Student? ( ) Full Time ( ) Part Time ( ) Not a Student

E-Mail address \_\_\_\_\_

Would you like to receive e-reminders for appointments? ( ) Yes ( ) No

Your Employer \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Occupation \_\_\_\_\_ ( ) Full Time ( ) Part Time ( ) Not Employed

Guarantor if covered under spouse's insurance OR a minor:

Name: \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Social Security # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Guarantor's Employer \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_

**EMERGENCY CONTACT:** \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

How did you hear about our office?

- ( ) Doctor Referral ( ) Family Member ( ) Newspaper Ad ( ) Radio Ad
- ( ) Emergency Room ( ) Adena Regional Medical Center ( ) Friend
- ( ) Co-Worker ( ) Insurance ( ) Newsletter ( ) Know an Employee Here
- ( ) Internet Web Site ( ) Other – Please list \_\_\_\_\_

Medical History

Name \_\_\_\_\_ Today's Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Height \_\_\_\_\_

Shoe Size \_\_\_\_\_ Weight \_\_\_\_\_

Reason for today's visit \_\_\_\_\_

Primary Care Physician \_\_\_\_\_ Date of last visit \_\_\_\_/\_\_\_\_/\_\_\_\_

Address of Physician \_\_\_\_\_

Physician's phone number \_\_\_\_\_

Pharmacy \_\_\_\_\_ Address \_\_\_\_\_

Pharmacy phone number \_\_\_\_\_

Have you seen a cardiologist? ( )Yes ( )No Dr \_\_\_\_\_

**Do you, or have you, had any of the following conditions:**

**Please check all that apply**

- |  |  |
|--|--|
| ( ) Diabetes<br>Since what age _____<br>Do you take<br>( ) Insulin ( ) Pills | ( ) Arthritis<br>( ) Rheumatoid Arthritis<br>( ) Raynauds Syndrome<br>( ) Depression |
| ( ) Family History of Diabetes   | ( ) History of Rheumatic Fever   |
| ( ) Breathing Problems   | ( ) Peripheral Vascular Disease<br>(Circulatory Problems)                            |
| ( ) Heart Problems   | if yes due to<br>_____   |
| ( ) Stomach Problems   |  |
| ( ) High Blood Pressure  |  |
| ( ) Abnormal Bleeding  |  |
| ( ) Fainting Spells/Seizures   | ( ) Do you Smoke   |
| ( ) T.B./Pneumonia   | How many years _____   |
| ( ) Liver problems or Hepatitis  | Packs per Day _____  |
| ( ) Kidney Disorders   | ( ) Use Alcohol  |
| ( ) Cancer   | ( ) Use Recreational Drugs   |
| Where _____  | ( ) Other diseases or Conditions   |
| When _____   | _____  |

**Please list any past surgeries and include dates**

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Chart # \_\_\_\_\_

(office use only)

Name \_\_\_\_\_

Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_

**Medications and Allergies**

**Please List All Current Medications and Dosage**

_____	_____
_____	_____
_____	_____
_____	_____

**Please List Any Allergies**

**If you do not have any known allergies, please write NONE**

\_\_\_\_\_

\_\_\_\_\_

**Release of Information**

Please list below any person(s) you would like to release your medical information to. This may include family members, physicians, or any entity you wish to disclose your individual identifiable information to. **Please note if no person(s) are listed we cannot release any of your information.**

_____	_____
_____	_____

I hereby instruct and direct that any and all payment (ins. Companies, collection agencies, ect.), be made directly to Southern Ohio Foot and Ankle Associates, Inc. (SOFAA). I am also releasing all medical records, if needed, to receive payment. I authorize SOFAA to deposit checks received for my account when made out to me. I also authorize the release of any information pertinent to my case to any insurance co., physician, hospital, adjuster, or attorney involved in this case.

In Medicare assigned cases and in-network insurances, we will bill and accept the allowable charge, and the patient is responsible for deductibles, co-insurance/co-payments, and non-covered services.

Out-of-Network insurances will be billed as a courtesy to you. The patient is responsible for services not paid by the insurance company.

If you fail to pay these charges, we may turn your account over to a collections agency, and will add a 30% interest charge to your account.

**By signing this, I understand and agree.**

I have read all the information on the previous pages and have completed all answers.  
I certify the information on all pages is correct and true to the best of my knowledge.  
I will notify you of any changes in my status, or changes of the previous information.

**Signed** \_\_\_\_\_ **Date** \_\_\_\_\_

**NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT**

Southern Ohio Foot and Ankle Associates, Inc.  
1130 Western Avenue, Chillicothe OH 4501  
1235 South Court Street, Circleville OH 43113  
740-775-7800

I understand that, under the Health Insurance Portability & Accountability act of 1996 (HIPPA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment, directly and indirectly.
- Obtain payment from third party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or healthcare operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name \_\_\_\_\_

Parent or Authorized Representative \_\_\_\_\_  
(If applicable)

Signature \_\_\_\_\_

Date \_\_\_\_\_

**Office Use Only**

I attempted to obtain the patient's signature in acknowledgement on this *Notice of Privacy Practices Acknowledgement*, but was unable to do so as documented below:

Date: \_\_\_\_\_

Initials: \_\_\_\_\_

Reason: \_\_\_\_\_