G. Daniel Shanahan IV, DPM
Jennifer Petronella, DPM

PATIENT INFORMATION

Account #: ____ /_____

NAME: _____
LAST FIRST MI

GENDER: □ MALE □ FEMALE D.O.B: _____

ADDRESS: _____

_____

_____
CITY STATE ZIP

PREFERRED PHONE #: _____ □ cell □ home

ALTERNATE PHONE #: _____ □ cell □ home

PREFERRED METHOD OF COMMUNICATION:
□ CALL □ TEXT □ EMAIL

EMAIL: _____

OCCUPATION: _____

PRIMARY PHYSICIAN: _____

CITY: _____ LAST SEEN: _____

PHARMACY: _____ PHONE #: _____

CROSS ROADS: _____CITY: _____

SHOE SIZE: _____ HEIGHT: _____ WEIGHT: _____

RECENT SURGERY: _____

DO YOU SMOKE? □ YES □ NO

DRUG ALLERGIES: _____

_____

OTHER ALLERGIES: _____

_____

PREVIOUS PODIATRIST: _____

DATE OF LAST VISIT: _____

MEDICAL HISTORY

Anemia	Yes	No
Arthritis	Yes	No
Artificial valves/joints	Yes	No
Asthma	Yes	No
Back Problems	Yes	No
Bleeding Disorders	Yes	No
Cancer	Yes	No
Chest Pain	Yes	No
Circulatory Problems	Yes	No
Diabetes	Yes	No
Eye Problems	Yes	No
Gout	Yes	No
Heart Disease	Yes	No
High Blood Pressure	Yes	No
High Cholesterol	Yes	No
Liver Disease	Yes	No
Respiratory Disease	Yes	No
Sleep Apnea	Yes	No
Stroke	Yes	No
Tuberculosis	Yes	No

MEDICATIONS: Name Dose

_____

_____

_____

_____

_____

_____

_____

_____

List any previous foot problems: _____

WHAT IS THE MAIN REASON FOR YOUR VISIT TODAY? _____

I hereby give my permission to Dr. Shanahan, Dr. Petronella and any associates to administer treatment as may be deemed necessary in the diagnosis and/or treatment of my foot condition(s). Additionally, I authorize the release of my medical information to my referring physician and other physicians and facilities that I am referred to. Lakes Foot and Ankle Associates (LFAA) has my permission to leave messages on my phone, text, and email regarding my treatment. If I choose to not have messages left, I will advise LFAA in writing. My signature represents my compliance with the *Lakes Foot and Ankle* Financial Policy. I will be given a copy of the Privacy Practices upon request.

SIGNATURE: _____ DATE: _____

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COMMUNICATIONS

Please list the person(s) we may contact regarding your treatment, care, appointments, or financial arrangements, including release of medical information:

Name: _____ Relation: _____

Phone Number: _____

Name: _____ Relation: _____

Phone Number: _____

Name: _____ Relation: _____

Phone Number: _____

If no one is listed in this section we will only be able to speak to you regarding your personal health information.

Emergency Contact: _____ Phone: _____

Who may we thank for referring you?

□ I am an existing patient.

Referred by:	***Name:***
Another Patient:	_____
Another Doctor:	_____
Family / Friend:	_____
Athletic Coach:	_____
Insurance Company:	_____
Community Event:	_____
Advertisement:	_____

Please Circle One

Internet: Sole Serenity Spa Building For Feets Sake

Our Website Google Facebook

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FINANCIAL POLICY

Thank you for choosing *Lakes Foot and Ankle Associates* (LFAA) for your Podiatric care. LFAA is committed to successfully treating all your foot and ankle needs. In an effort to provide personalized patient care in the most efficient manner, we ask that you read our complete Financial Policy.

- All fees pertaining to your treatment are due when services are rendered. This may include, but is not limited to copays, deductibles, and outstanding balances.
- Payment for medical equipment, products, and supplies is due at time of dispensing.
- Acceptable forms of payment include cash, check, Visa, MasterCard, Discover, American Express, and Care Credit.
- Fees for evaluation and treatment vary depending on the complexity of your condition and the treatment required.

As a courtesy to you, LFAA will submit your claims to your insurance company. You will be responsible for any fees that are not covered by your insurance company. Please see additional responsibilities below.

Patient Responsibilities

- Confirm that LFAA participates with your insurance plan
- Provide a referral, if your insurance plan requires it, prior to your appointment
- Provide LFAA with your insurance information, including secondary insurance
- Remit payment for copays, deductibles, and outstanding balances at time of service
- Respond to any questions or requests for information from your insurance company that may delay processing of your claim
- Promptly remit payment upon receiving a statement
- Inform LFAA of any changes in your demographics or insurance policies

As an LFAA patient, you authorize release of your medical information to any third party payer, or its representative, which may be responsible for payment of claims. As required by law, such information from your medical record is necessary in order to receive reimbursement for any billing rendered relating to your treatment. You also assign all insurance benefits for, payable for services rendered, to G. Daniel Shanahan IV, DPM, PC.

Past due accounts are subject to collection proceedings, which may include additional fees.