G. Daniel Shanahan IV, DPM
Jennifer Petronella, DPM

Lakes FOOT & ANKLE ASSOCIATES

PATIENT INFORMATION

Account #: ____ /______

NAME: ____
LAST FIRST MI

GENDER: ☐ MALE ☐ FEMALE D.O.B: __________________

Social Security #_____________________________________

Address____

____
CITY STATE ZIP

PREFERRED PHONE #: ____________________ ☐ cell ☐ home

ALTERNATE PHONE #: ____________________ ☐ cell ☐ home

PREFERRED METHOD OF COMMUNICATION:
☐ CALL ☐ TEXT

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

Condition		
Amyloidosis	Yes	No
Arthritis	Yes	No
Artificial valves/joints	Yes	No
Asthma	Yes	No
Back Problems	Yes	No
Bleeding Disorders	Yes	No
Blocked Arteries	Yes	No
Cancer	Yes	No
Celiac Disease	Yes	No
Chest Pain	Yes	No
Circulatory Problems	Yes	No
Diabetes	Yes	No
Gout	Yes	No
Heart Disease	Yes	No
High Blood Pressure	Yes	No
High Cholesterol	Yes	No
Kidney Disease (chronic)	Yes	No
Liver Disease	Yes	No
Multiple Sclerosis	Yes	No
Raynaud's Syndrome	Yes	No
Respiratory Disease	Yes	No
Stroke	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: ____________________

G. Daniel Shanahan IV, DPM
Jennifer Petronella, DPM

COMMUNICATIONS

Please list the person(s) we may contact regarding your treatment, care, appointments, or financial arrangements, including release of medical information. Do not include yourself.

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: _________________________________
- ☐ Building
- ☐ For Feets Sake
- ☐ Lakes Foot & Ankle Website
- ☐ Google
- ☐ Facebook

G. Daniel Shanahan IV, DPM
Jennifer Petronella, DPM

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. To provide personalized patient care, in the most efficient manner, we ask that you read our complete Financial Policy. **Initial**

- **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.
- Know your coverage and benefits.
- Provide a referral, if our 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 the 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 to receive reimbursement for any billing rendered relating to your treatment. You also assign all insurance benefits, payable for services rendered, to G. Daniel Shanahan IV, DPM, PC.

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

SIGNATURE: ____ DATE: ____________________