Welcome

Alaska Foot & Ankle Specialists

Date: _____

Last Name: _____ First: _____ MI:____

Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Work Phone: _____ Message Phone: _____

Date of Birth: _____ Gender: ☐ Male ☐ Female SSN#: _____

Employer: _____ Occupation: _____

Employment: ☐ Full Time ☐ Part Time ☐ Seasonal ☐ Self-Employed Marital Status: ☐ S ☐ M ☐ W ☐ D

If Patient is a Minor Parent or Legal Guardian Name: _____

Employer: _____ Date Of Birth: _____ SSN#: _____

Contact Phone: _____

Emergency Contact: (Last, First, MI) _____ Relationship: _____

Home Phone: _____ Work Phone: _____ Work Extension: _____

Primary Insurance Company: _____

Employer: _____

Name of Policy Holder: _____

Date of Birth: _____ SSN#: _____ Relationship to Patient: _____

Financial Responsibility and Assignment of benefits: I hereby acknowledge and understand that I am financially responsible for all charges incurred on my (or my dependent's) behalf whether or not paid by insurance. I authorize the use of this signature on all insurance submissions and that my insurance benefits be paid directly to Dr. Heilala. I understand that it is the policy of this office for accounts outstanding over 90 days be turned over to collections unless other arrangements are made. In the event that my account is sent to collections, I acknowledge responsibility for any additional costs incurred. I also certify that I have declared all insurance coverage to this office.

Responsible Party Signature: _____

Relationship to Patient: _____ Date: _____

How did you find us? (check only one)

- ☐ AK State Medical directory
- ☐ Anchorage Daily News
- ☐ Catholic Anchor
- ☐ Big Game Promotions ads
- ☐ My Doctor: _____
- ☐ Anch Daily News website
- ☐ Our AFAS website
- ☐ Yahoo website
- ☐ Google website
- ☐ ACS yellow pages
- ☐ GCI yellow pages
- ☐ MTA yellow pages
- ☐ The Local Pages
- ☐ Other: _____
- ☐ Healthwise video segment
- ☐ Alyeska Resort
- ☐ Lumen Christi High School

Patient Name: (Last, First, MI) _____ Date Of Birth: _____ Age: _____

Referring Physician: (If applicable) _____

What is the chief complaint for which you came to be treated? (Please include foot, ankle, knee, thigh, and hip complaints): _____

_____

Cigarette/Tobacco use? ☐ Yes ☐ No Number of years _____ Is there a family history of Diabetes? ☐ Yes ☐ No

Do you drink alcohol? ☐ none ☐ daily ☐ weekly ☐ monthly

Check all that apply to indicate if **YOU** have a history of the following:

Aids/HIV	☐ Yes ☐ No	Anemia	☐ Yes ☐ No	Arthritis	☐ Yes ☐ No
Back Problems	☐ Yes ☐ No	Blood/Bleeding Disorders	☐ Yes ☐ No	Cancer _____	☐ Yes ☐ No
Chemical/Drug Dependent	☐ Yes ☐ No	Circulatory Problems	☐ Yes ☐ No	Radiation or Chemo	☐ Yes ☐ No
Diabetes	☐ Yes ☐ No	Ear Problems	☐ Yes ☐ No	Epilepsy	☐ Yes ☐ No
Eye Problems	☐ Yes ☐ No	Fainting	☐ Yes ☐ No	Foot or Leg Cramps	☐ Yes ☐ No
Gout	☐ Yes ☐ No	Headaches	☐ Yes ☐ No	Heart Disease	☐ Yes ☐ No
High Blood Pressure	☐ Yes ☐ No	Hormone Disorder/Thyroid	☐ Yes ☐ No	Implants Prosthetics	☐ Yes ☐ No
Stroke	☐ Yes ☐ No	Kidney Problems	☐ Yes ☐ No	Liver Disease	☐ Yes ☐ No
Low Blood Pressure	☐ Yes ☐ No	Nervous Problems	☐ Yes ☐ No	Hepatitis or Jaundice	☐ Yes ☐ No
Phlebitis/Blood Clots	☐ Yes ☐ No	Psychiatric/Mood Issues	☐ Yes ☐ No	Respiratory/Breathing Issues	☐ Yes ☐ No
Rheumatic Fever	☐ Yes ☐ No	Shortness of Breath	☐ Yes ☐ No	Sinus Problems	☐ Yes ☐ No
Special Diet	☐ Yes ☐ No	Swelling in Ankles or Feet	☐ Yes ☐ No	Swollen Neck Glands	☐ Yes ☐ No
Infections	☐ Yes ☐ No	Ulcers _____	☐ Yes ☐ No	Varicose Veins	☐ Yes ☐ No
Venereal Disease	☐ Yes ☐ No	Weight Issues	☐ Yes ☐ No		

Please list all current illnesses that you are suffering from: _____

Please list any hospitalizations or surgeries in the last 5 years: _____

Family physician: _____ Last visit date: _____

Are you now, or have you been, under any other doctor's care for any other reason over the past 2 years? ☐ Yes ☐ No

If "Yes" please explain: _____

Please list all medications that you are currently taking, include prescriptions, over-the-counter medications and vitamins:

_____

Do you take oral contraceptives or blood thinners? ☐ Yes ☐ No

ALLERGIES (check all that apply)

☐ Adhesive/Tape ☐ Anticoagulant Therapy ☐ Aspirin ☐ Codeine ☐ Demerol ☐ Iodine

☐ Local Anesthetics ☐ Novocain ☐ Penicillin ☐ Seafood ☐ Sulfa ☐ Other: _____

☐ NO KNOWN DRUG ALLERGIES

I certify that the above information is true and correct to the best of my knowledge. I give my permission to the doctor to administer and perform such procedures as deemed necessary in the diagnosis and/or treatment. I accept financial responsibility for all charges incurred.

Patient or Legal Guardian Signature: _____ Date: _____