Welcome

Patient Information Sheet

Mallette FOOT&ANKLE

Primary Care Physician _____ Referred By _____

How did you hear about us? _____ Date _____

Please complete **all forms**. Once complete please bring the forms, insurance card and photo id to the front desk receptionist. Thank You

Patient Name _____ DOB _____

Street Address _____

Are you currently residing in a nursing facility? Yes ○ No ○ If yes, Facility: _____

Home# _____ Cell# _____ Email _____

SS# _____ Pharmacy _____ Location _____

Employer _____ Work # _____ Occupation _____

Status ○ Single ○ Married ○ Divorced ○ Widowed | **Sex** Male ○ Female ○

Race (Check all that apply)
○ White ○ American Indian or Alaska Native ○ Asian ○ Black or African American ○ Hispanic or Latino ○ Native Hawaiian or Other Pacific Islander

Living Will? Yes ○ No ○ Spouse _____ Phone # _____

Emergency Contact _____ Relationship _____ Phone # _____

GUARANTOR
Complete this box **only** if patient is a minor.

Name of Responsible Party _____ DOB _____

Relationship _____ Phone # _____

Address if Different _____ Occupation _____

INSURANCE INFORMATION
Please fill in **all** areas.

Primary Insurance Carrier: Aetna _____ Group # _____ Policy # _____

Secondary Insurance Carrier: _____ Group # _____ Policy # _____

Your health insurance program may have limits that will affect your charge at our office. Some insurance companies will not pay for certain tests or office visit and will be your responsibility. We accept assignment with numerous insurance carriers. Please check with our front desk to identify your insurance carrier. If you do not have insurance through one of these carriers, then you are responsible for submitting claims and payment will be due at time of service.

I HAVE READ AND UNDERSTAND THE ABOVE and hereby give my consent to any physician member or designee to provide medical treatment to me encompassing diagnostic and therapeutic procedures.

Signature _____ Print Name _____ Date _____

Patient History

Information Sheet

Mallette FOOT&ANKLE

Patient Name _____ Date _____

Your insurance company requires the following information for proper payment. Please fill out completely.

DOB _____

Reason For Today's Visit

_____

Timing of Problem

- ☐ Continuous
- ☐ Intermittent (Comes And Goes)

Location

- ☐ Left
- ☐ Right

Quality

- ☐ Sharp
- ☐ Dull
- ☐ Irritating
- ☐ Burning
- ☐ Throbbing
- ☐ (Other)

Duration of Symptoms

- ☐ Days
- ☐ Weeks
- ☐ Months
- ☐ Years

Severity of Symptoms

- ☐ Mild
- ☐ Moderate
- ☐ Severe

*Modifying Factors

Things that make it worse:

Things that make it better:

*Symptoms

Previous Treatment

Have you tried Medications for these symptoms?

☐ Yes ☐ No

If yes what medications:

Other form of therapy / treatment:

X-Rays, Cat Scans, MRI or Lab Work

in the last year related to current illness /problem?

- ☐ Yes
- ☐ No

When: _____

Where: _____

* Must be completed

Signature _____ Date _____

Melbourne Office 200 South Harbor City Boulevard, Suite 102 Melbourne, Florida 32901
Viera Office 7000 Spyglass Court, Suite 230 Viera, Florida 32940

(P) 321.728.0117
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Patient History

Information Sheet

Mallette FOOT&ANKLE

Patient Name Date

Your insurance company requires the following information for proper payment. Please fill out completely. DOB

Medications

Please list ALL current medications:

(1) (7)
(2) (8)
(3) (9)
(4) (10)
(5) (11)
(6) (12)

***Past Surgical History**

***Allergies**

Medical History

Family History

	Relation		
☐ Anesthesia Complications	☐ Mother	☐ Father	☐ Grandparent
☐ Asthma	☐ Mother	☐ Father	☐ Grandparent
☐ Bleeding Problems	☐ Mother	☐ Father	☐ Grandparent
☐ Diabetes	☐ Mother	☐ Father	☐ Grandparent
☐ Hearing Loss	☐ Mother	☐ Father	☐ Grandparent
☐ Heart Disease	☐ Mother	☐ Father	☐ Grandparent
☐ Seizures	☐ Mother	☐ Father	☐ Grandparent
☐ Stroke	☐ Mother	☐ Father	☐ Grandparent
☐ Thyroid Disorders	☐ Mother	☐ Father	☐ Grandparent
☐ Cancer	☐ Mother	☐ Father	☐ Grandparent

*** Social History**

☐ MIRSA Infection
☐ HIV / AIDS
☐ Smoker
☐ Former Smoker
☐ Alcohol

If **yes**, How many per day? _____

☐ Latex Allergy

* Must be completed

Signature _____ Date _____

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Patient History

Medical History and Review of Systems

Mallette FOOT&ANKLE

Have you experienced any of the following ?

Please select All your medical conditions below.

General

- ☐ Chills
- ☐ Fever
- ☐ Weight Gain/Loss
- ☐ Loss of Appetite
- ☐ Fatigue
- ☐ Night Sweats
- ☐ Insomnia
- ☐ Weakness
- ☐ Headaches
- ☐ Dizziness

Eyes

- ☐ Red Eyes
- ☐ Change in Vision
- ☐ Cataracts
- ☐ Blurring Visions
- ☐ Dry Eyes
- ☐ Corrective Lenses
- ☐ Glaucoma
- ☐ Vision Loss

GI

- ☐ Persistent Nausea/ Vomit
- ☐ Bloody Stools
- ☐ Indigestion/ Heartburn
- ☐ Ulcer
- ☐ Gastritis
- ☐ Hepatitis
- ☐ Diverticulitis
- ☐ Diarrhea
- ☐ Constipation

Skin

- ☐ Rashes/Hives
- ☐ Cancer (Where _____)
- ☐ Easy Bruising
- ☐ Wounds
- ☐ Itching
- ☐ Infection (MRSA)
- ☐ Changes In Moles
- ☐ Callus
- ☐ Deformed Nails
- ☐ Raynaud's
- ☐ Sores

Heart

- ☐ Chest Pain/ Angina
- ☐ Previous Heart Surgery
- ☐ Palpitations/ Irregular Heart Beat
- ☐ Shortness of Breath
- ☐ Heart Attack
- ☐ Anemia
- ☐ Pacemaker/Defibrillator
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Heart Disease
- ☐ Arterial Fibrillation

Muscle/Joint

- ☐ Joint Redness
- ☐ Joint Pain
- ☐ Joint Swelling
- ☐ Joint Stiffness
- ☐ Arthritis
- ☐ Fibromyalgia
- ☐ Osteopenia
- ☐ Back Pain
- ☐ Sciatica
- ☐ Fractures
- ☐ Sprains
- ☐ Tendonitis
- ☐ Lack of Coordination
- ☐ Multiple Sclerosis
- ☐ Friedreich Ataxia

Neurology

- ☐ Memory Loss
- ☐ Seizures
- ☐ Muscle Weakness
- ☐ Stroke
- ☐ Parkinson's
- ☐ Tremors
- ☐ Restless Leg Symptoms
- ☐ Tingling/ Numbness
- ☐ Balance Issues
- ☐ Gait Difficulty
- ☐ Peripheral Neuropathy

Psychology

- ☐ Anxiety
- ☐ Depression
- ☐ Sleep Disturbances
- ☐ High Stress Level
- ☐ Panic Attacks
- ☐ Suicidal Ideation
- ☐ Eating Disorder

Lungs

- ☐ Wheezing
- ☐ Chronic Cough
- ☐ Uses Oxygen at Home
- ☐ Asthma
- ☐ Emphysema
- ☐ Fatigue
- ☐ Bronchitis
- ☐ Tuberculosis
- ☐ Sleep Apnea

Endocrine

- ☐ Diabetes
- ☐ Thyroid LOW or HIGH

Excessive:

- ☐ Sweating
- ☐ Thirst
- ☐ Urination
- ☐ Cold Intolerance
- ☐ Heat Intolerance
- ☐ Kidney Problems
- ☐ Liver Problems
- ☐ Alcoholism

Signature _____

Date _____

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Financial Policy

Mallette FOOT&ANKLE

Financial Policy
The following is a statement of our Financial Policy, which we would like you to read and sign prior to any services being rendered.

Usual and Customary Rates
Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area.

Self-Pay
Balances are due at the time of the visit. An estimate of services can be provided prior to you being seen by our physicians. Understanding that this is an estimate and balance will be due at your visit.

Participating Insurance Plans
It is the patient's responsibility to understand their insurance and know who the in-Network providers are as well as the deductibles and copays associated with their plan. In order to properly bill your insurance company and avoid untimely delays, we require that you provide us with your insurance information and allow us to keep copy of your insurance cards on file. For those plans with which we are a participating provider, all co-pays, deductibles and co-insurances are due at the time of service. Deductibles and co-insurances are an ESTIMATE and any remaining balances would be due when a statement is received from our billing department.

For those patients requiring a referral or authorization for service from their Primary Care Provider, please bring all the information with you to your appointment.

Non- Participating Insurance Plans
We do require that payment be made in full at the time of service if you have an insurance plan we accept. In addition to check or cash, we accept MASTERCARD, VISA and DISCOVER. We will provide you with an itemized receipt of your charges. This can be used for any insurance claims you want to process after your visit.

Secondary Insurance
We will be happy to file your secondary insurance if you provide us with the necessary information. If you do not provide us with secondary insurance information, you will be responsible for filing any claims with the insurance. Thank you for your understanding of this Financial Policy. Please let us know if you have any questions or concerns.

Medical Authorization
I authorize Dr. Brian J Mallette and/or Dr. Claudia R. Mallette to furnish complete medical information to my insurance or its intermediaries regarding services rendered.

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES
I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read if I so chose) and understand the notice. Copy of privacy practices are available upon request.

Signature _____ Print Name _____ Date _____

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HIPAA PRIVACY

Authorization Form

Mallette FOOT&ANKLE

Please initial all that apply and complete information requested.

Please read through the following statements and initial next to each one that you agree to.

Initial

_____ I give my permission for Mallette Foot and Ankle to leave messages on my answering machine regarding my scheduled appointments.

_____ I give my permission for Mallette Foot and Ankle to leave messages on my answering machine regarding payment information.

_____ I give my permission for Mallette Foot and Ankle to discuss my medical care with the following persons other than myself:

Name _____ Relationship _____

Name _____ Relationship _____

_____ I give my permission for Mallette Foot and Ankle to discuss payment information with the following persons other than myself:

Name _____ Relationship _____

Name _____ Relationship _____

Signature _____ Print Name _____ Date _____

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