G. Adam Shapiro, DPM, FACFAS
Diplomate, Am. Board of Podiatric Surgery
Board Certfied in Foot Surgery
Joe K. Ades, DPM
Podiatric Foot & Ankle Surgeon

Thank you for choosing Dr. Shapiro, Dr. Ades and the wonderful staff of Foot & Ankle Associates.

Since 1998, Foot & Ankle Associates has been here to provide the best possible medical and surgical foot and ankle care for adults and children. Along with specialized training and the newest technology, we offer kindness and respect for every patient. We look forward to getting to know you, giving you the care you need, and getting you back up to speed.

Our knowledgeable, sensitive, and well-trained staff will be happy to assist you in every way.

Our mission is to provide the best possible comprehensive foot and ankle care in a comfortable, respectful, and professional environment.

To expedite your check-in process, please complete the enclosed paperwork to bring with you on the day of your appointment.

For your first visit, it is important that you also bring the following information with you:

1. A list of your medications, both prescription and over-the-counter.
2. Your insurance card.
3. Your physician's name and phone number as well as any written referral information.

Payments for services not covered by your insurance plan or from any insurance co-payment, co-insurance, and/or deductible are expected at the time of service. If you have any questions or concerns regarding billing issues, please contact either your insurance carrier or our billing office at (704) 662-3660. For your convenience, we accept cash, checks and Visa/Mastercard.

For more information or directions to our clinics, you can visit our website at www.footandankleassociates.com.

We look forward to your visit.

foot & Ankle ASSOCIATES
Caring for Your Every Step.

MEDICAL HISTORY

Name of Primary Physician:________________________________Last Seen (Month/Year)________________

Describe the reason for your visit today:____

Have you ever been diagnosed and/or treated for any of the following? Please check below.

___ Diabetes (Do you take Insulin? Y/N) ___ Heart Problems ___ Circulation Trouble
___ Cancer/Tumors (Specify________________________) ___ Mental Disease
___ Stroke ___ High Blood Pressure ___ Nerve Problems ___ Kidney/Bladder Disease
___ Arthritis ___ Gout ___ Breathing Problems ___ Asthma
___ Anemia ___ Thyroid Disease ___ Stomach Problems ___ Bleeding Tendencies
___ Seizures ___ HIV (+) ___ Back Pain or Injury ___ Foot wound or ulcer
___ Blood Clots ___ High Cholesterol ___ Liver Problems (Specify_____________________)

List any medications you take:	Dosage/Frequency	What is it for?
__________________________	________________	_______________
__________________________	________________	_______________
__________________________	________________	_______________
__________________________	________________	_______________
__________________________	________________	_______________
__________________________	________________	_______________
__________________________	________________	_______________
__________________________	________________	_______________
__________________________	________________	_______________
__________________________	________________	_______________
__________________________	________________	_______________

Do you have any allergies? Please list.

____

Have you had any surgeries? Please List.

Year	Type of Surgery
_____________	____
_____________	____
_____________	____

Do you smoke? ____Yes____No How many packs per day?____for____years.

Do you drink? ____Yes____No How much?___________________________

Are you pregnant? ____Yes____No Are you claustrophobic? ____Yes____No

Is there any metal in your body? ____Yes____No Were you ever a welder?____Yes____No

What is your: Height?:____ft.____inches Weight?:______lbs. Shoe size?:______

Who may we thank for referring you to our practice?______________________________

PATIENT INFORMATION

_______________________________________ M S D W Y N M F
Patient Name Maritial Status Are you employed? Sex

____
Mailing Address City State Zip

(_______)_________________ (_______)_______________ (_______) ____________________
Home Phone# Work Phone# Cell Phone#

_____________________ _____________________ __________ ____________
Social Security# E-mail address Age DOB

_________________________ ________________ _________________________ (______)______________
Employer Name Occupation Primary Care Physician Phone #

___________________________ _______________________ (______)________________
Parent/Guardian Name Relationship to Patient Phone#

_________________________ _______________________ (______)________________
Emergency Contact Relationship to Patient Phone#

________________________ ________________
Primary Insurance Co ID#

______________________ __________________________ __________ _________________
Policy Holder Name Employer DOB SSN#

________________________ ________________
Secondary Insurance Co ID#

______________________ __________________________ __________ _________________
Policy Holder Name Employer DOB SSN#

I wish to be contacted: (check all that apply)

- ☐ Email (Provided above)
- ☐ Home / Work / Cell Phone (circle all that apply)
- ☐ Mailing address (Provided above)

May we leave a detailed message? Y N
____

Authorization for treatment by Foot & Ankle Associates: I present myself or child for whom I am guardian for treatment, diagnoses and other services as deemed necessary of advisable by my doctor.

Medicare/Medicaid Patient's Certification: I certify the information given by me in applying for payment under Title XVIII and XIX of the Social Security Act is correct. I request payment be made directly to the provider of services on my behalf and I authorize said provider to release any and all information necessary regarding the treatment and services provided as stated below.

Assignment of Benefits: I hereby authorize payment directly to Foot & Ankle Associates by my insurance carrier(s). In the event that payment is received from more than one insurance company creating an overpayment I understand that the overpayment will be sent to the appropriate payor. In the event overpayment is created due to my payment, I authorize the transfer of the overpayment to any unpaid bill of Foot & Ankle Associates for which I am responsible.

Payment of Services: I understand that I am financially responsible for all charges and fees related to the treatment and services rendered to me by Foot & Ankle Associates. I further understand that payment is expected at the time of each office visits to include co-payments, deductibles and any services not covered by my insurance.

____________________________________ _______________________
Patient Signed Name (Guardian Name if a minor) Date

____________________________________ _________________________
Patient Printed Name (Guardian Name if a minor) Relationship to patient

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HOW DID YOU HEAR ABOUT US?

Would you please take a moment and tell us how you heard about our practice. Please select as many of the following that apply to you. ***Thank you for helping us determine how our advertising is working for us!***

NAME:_______________________________ DATE OF TREATMENT:_____________________

Saw Advertisement in the Newspaper

- ☐ Charlotte Observer – Neighbors of Lake Norman
- ☐ Charlotte Observer – Neighbors of University City
- ☐ Huntersville Herald
- ☐ Mooresville Tribune
- ☐ Other: _______________________

Saw Advertisement in the Yellow Pages

- ☐ Bellsouth Yellow Pages – Lake Norman
- ☐ Bellsouth Yellow Pages – Charlotte
- ☐ Windstream Phone Book – Mooresville
- ☐ Other: _______________________

Found Information on the Internet

- ☐ Insurance Provider Website
- ☐ Yellow Pages Internet Listing
- ☐ www.footandankleassociates.com
- ☐ Other: _______________________

Direct Mail/Delivery

- ☐ Information received in the mail
- ☐ Information delivered to my home
- ☐ Other: _______________________

Other:

- ☐ Health Fair: Which one?____
- ☐ I was referred by a friend/family member. Who? _______________________
- ☐ I was referred by a physician: Who? _______________________________
- ☐ I saw signage or banner: Where? _________________________________
- ☐ Other: (Please specify) ____

143 Joe Knox Avenue
Suite 100
Mooresville, NC 28117
704.662.3660 ph
704.662.3595 fx

16623 Birkdale Commons Pkwy
Suite 120
Huntersville, NC 28078
704.892.5575 ph
704.892.6566 fx

3220 Prosperity Church Rd
Suite 101
Charlotte, NC 28269
704.971.7100 ph
704.971.7101 fx

www.footandankleassociates.com