Johnston Foot and Ankle Clinic
5335 Merle Hay Rd
Johnston, IA 50131

PATIENT INFORMATION:

First Name: ____________________ Last Name: ___________________ M _______ Nick Name: ________________

Address: ____ City: _________________ ST: ___ Zip: _____________

Home Phone: ____________________ Cell: ___________________ Email: _________________________________

Marital Status: _____________ Social Security Number: _____________ Date of Birth: ___________Sex: ☐M ☐F

Spouse Contact: __________________________ _______________________ ______________________________
(Name) (Relationship) (Phone)

Emergency Non-spouse Contact : ____________________ _______________________ ________________________
(Name) (Relationship) (Phone)

Do we have permission to talk to these persons regarding your health? Yes No

Preferred reminder type: Call No reminder call

INSUREDS INFORMATION: (Who carries the policy. Spouse, parent, who is in charge of the financial responsibility.)

First Name: ____________________________ Last Name: ______________________________ Middle Initial: _______

Address: ____ City: _______________ ST: _____ Zip: _____________

Cell Phone: ___________________ Date of Birth: ______________ Relationship to Patient: _____________________

Guarantor information (if applicable): ____
(Name) (Phone) (Address) (City) (ST) (Zip)

ADDITIONAL INFORMATION

Primary Care Physician: ________________ Last Seen: __________ City: _______________ ST: ___

Preferred Pharmacy: __________________________________ _____________________ __________ ___________
Name City ST Zip

Employer Information: ______________________________ ____
Name Phone Number

Please list any/all medications and dosages: (If you do not take any medications leave blank)

Medication	Dose	Medication	Dose

Do you have any allergies? (Please describe) ____

What is your: Height ____________________ Weight ________________________

What are you being seen for today? ____

PAST MEDICAL HISTORY (Please check all that apply)

☐None
☐Anxiety Disorder
☐Back Spine or Disc Disease
☐Clotting disorder
☐Depression
☐Diabetic
☐End Stage Renal Disease
☐Heart Disease
☐High Cholesterol
☐Hypertension
☐Liver Disease
☐History of DVT or Blood Clot
☐Neuropathy or Nerve pain
☐Pulmonary Embolism
☐Prosthetic Joint(s)
☐Peripheral Vascular Disease
☐Numbness in feet
☐Foot Ulcer or sores
☐Rheumatoid Arthritis
☐Other ___________________________________

PAST SURGICAL HISTORY

☐**Knee Arthroscopy** ☐Right ☐ Left ☐Both
☐**Knee Replacement** ☐ Right ☐ Left ☐Both
☐**Hip Replacement** ☐Right ☐ Left ☐ Both
☐**Foot** ☐Right ☐ Left ☐Both
☐**Ankle** ☐ Right ☐Left ☐Both

Are there any other surgeries we should be aware of? ____

FAMILY HISTORY:

Mom: ☐Diabetes ☐Cancer ☐ High blood pressure Cholesterol ☐Stroke ☐ Other______________
Dad: ☐Diabetes ☐Cancer ☐ High blood pressure Cholesterol ☐Stroke ☐ Other______________

Social History:

Smoking Habits: ☐Current smoker? ☐Y ☐N ☐Former Smoker? ☐Y ☐N Quit Date: _____________
Alcohol: Do you consume alcohol? ☐Y ☐N Number of Drinks in a week: _____________
Drug Use: Do you use recreational drugs? ☐Y ☐N

How did you hear about us? ____

I/We do hereby consent to and authorize the performance of any/all treatments, surgeries and/or medical services deemed advisable by Dr. Dana L. Plew, DPM at Johnston Foot & Ankle Clinic, to me or to the above-named minor of whom I am the parent or legal guardian. I hereby certify that to the best of my knowledge, all statements contained hereon are true. I understand that I am directly responsible for all charges incurred for medical services for myself and/or my dependent(s) regardless of insurance coverage. I furthermore agree to pay legal interest, collection expenses, and attorney fees incurred to collect any amount I may owe. I also hereby authorize Johnston Foot & Ankle to release any/all information requested by insurance companies and/or its representatives, collection agencies and/or any attorney's office and/or any physician, surgery center or hospital. The signature below will also count as my "signature on file" for any/all insurance purposes. I fully understand this agreement and consent will continue until cancelled by me in writing.

I have had the opportunity to review the HIPAA agreement.

Print Name of Patient or Responsible Party: ___________________________ Date: _________________

Signature of Patient or Responsible Party: ____________________________ Date: _________________

NO SHOW POLICY FOR JOHNSTON FOOT AND ANKLE CLINIC

As a courtesy to our office as well as the patients that are waiting to schedule with the physician, please give us at least 24-hour notice if needing to reschedule your appointment. ***If you do not cancel or reschedule your appointment with at least 24-hour notice, we may assess a $50.00 "no show" service charge to our account.*** "I acknowledge that I read and understand this policy".
Signature of Patient or Responsible Party: ____________________________ Date: __________________