Raymond J. Abdo, DPM
St. Louis Foot and Ankle, LLC.
12152 Tesson Ferry Road
St. Louis, MO 63128
314-849-7600

PATIENT APPOINTMENT

PLEASE ARRIVE 15 MINUTES PRIOR TO YOUR SCHEDULED APPOINTMENT TIME

Please bring the following information with you:

PHOTO ID
INSURANCE CARD (S)
CO-PAYMENT
REFERRAL (IF APPLICABLE)
CURRENT LIST OF MEDICATIONS (PRESCRIPTION AND OVER-THE-COUNTER)

Please note that small children are not allowed in the examination room. If it is necessary to bring children with you to your appointment, please make arrangements for their supervision, while you meet with the doctor.

Kindly give our office a ***minimum of 24 hours notice*** if you find you are unable to keep this appointment or wish to change/cancel the appointment.

If you have any questions, or if I can be of any further assistance, please feel free to call my office.

Professionally yours,

Bonnie L. Weiss
Practice Manager

ST. LOUIS FOOT AND ANKLE, LLC.
RAYMOND J. ABDO, DPM

NAME: _____ SEX F____ M ____
(FIRST) (MIDDLE) (LAST)

ADDRESS _____ CITY _____ STATE/ZIP _____

SOCIAL SECURITY NUMBER _____ EMAIL _____

HM PHONE _____ WRK PHONE _____ CELL PHONE _____

DATE OF BIRTH _____ AGE _____ MARITAL STATUS _____

PT EMPLOYER _____ OCCUPATION/JOB TITLE _____

IN CASE OF EMERGENCY CONTACT (NAME) _____ RELATIONSHIP _____

FIRST PHONE NUMBER _____ ALTERNATE PHONE NUMBER _____

PRIMARY CARE DOCTOR _____ OFFICE PHONE _____
(FIRST) (LAST)

PRIMARY PHARMACY _____ PHARMACY PHONE _____

INSURANCE CARRIER INFORMATION

PRIMARY INSURANCE: MEDICARE UNITEDHEALTHCARE ANTHEM BC/BS COVENTRY CIGNA AETNA HEALTHLINK

PRIMARY INSURED NAME: _____ DATE OF BIRTH _____

SOCIAL SECURITY NUMBER _____ RELATIONSHIP TO PATIENT _____

EMPLOYER NAME _____
(IF INSURANCE COVERAGE IS THROUGH AN EMPLOYER)

PLEASE READ CAREFULLY

I agree to pay, in addition to the amount billed for services rendered, a collection fee of not more than thirty percent (30%) of the principal balance, if St. Louis Foot and Ankle, LLC. employs a collection agency to attempt to collect an unpaid balance.

I consent to be called on any telephone number I give St. Louis Foot and Ankle, LLC. including cellular telephone numbers. I understanding St. Louis Foot and Ankle, LLC. and or its agency will be calling my contact numbers, including any cellular telephone numbers, using an automated telephone dialing system.

I hereby authorize release of information necessary for my insurance company to process any claim. The above information is correct to the best of my knowledge.

I hereby authorize payment directly to St. Louis Foot and Ankle, LLC. . insurance payments otherwise payable to me. I understand that I am financially responsible for charges not paid in a timely manner by my insurance company.

PATIENT SIGNATURE _____ DATE _____

St. Louis Foot and Ankle, LLC.
12152 Tesson Ferry Road
St. Louis, MO 63128
314-849-7600

The following signature authorizes **Raymond J. Abdo, DPM,** or his designated associate (s), to communicate with the following person (s) regarding my protected health information records, including test results or any other information needed for diagnosis or treatment. This will also include information to insurance companies for resolution of claims.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations.

Please list the persons with whom we may communicate regarding appointments, test results, etc. Example: spouse, significant others, family members or friends.
No need to list any doctors, attorneys or caseworkers.

I authorize communication with the following person (s):

1. _____ _____
Name Phone number

_____ _____
Relationship Alternate number

2. _____ _____
Name Phone number

_____ _____
Relationship Alternate number

3. _____ _____
Name Phone number

_____ _____
Relationship Alternate number

This authorization will remain in effect from : ***TODAY*** until ***FURTHER NOTICE.***
I understand that I may change or revoke this authorization, in writing, at anytime.

_____ _____
Signature Date

_____
Practice Representative/Witness

NAME: _____ DATE: _____

PREFERRED PHARMACY _____ Phone: _____

City: _____Zip code: _____ Cross streets_____

ARE YOU ALLERGIC TO LATEX? ____Yes ____ No

ARE YOU ALLERGIC TO ANY MEDICATIONS ? ____Yes ____ No

Drug: _____ Reaction: _____

Drug: _____ Reaction: _____

Drug: _____ Reaction: _____

ARE YOU TAKING ANY OF THE FOLLOWING OVER-THE-COUNTER MEDS: ___Yes ___ No

_____ ALLERGY _____ ANTACIDS _____ ASPIRIN/TYLENOL _____ LAXATIVES _____ DIET PILLS

NAME OF MEDICATION	STRENGTH (mg or mcg)	HOW MANY	HOW OFTEN

PRESCRIPTION MEDICATIONS

NAME OF MEDICATION	STRENGTH (mg or mcg)	HOW MANY	HOW OFTEN

VITAMINS, HERBS AND SUPPLEMENTS

NAME: _____ DATE: _____

SURGICAL HISTORY:

Have you ever had surgery: _____ Yes _____ No
If yes, please list:

1. _____ Date: _____
2. _____ Date: _____
3. _____ Date: _____
4. _____ Date: _____
5. _____ Date: _____
6. _____ Date: _____
7. _____ Date: _____
8. _____ Date: _____
9. _____ Date: _____
10. _____ Date: _____

NAME: _____ DATE: _____

HEIGHT: _____ **WEIGHT:** _____ **SHOE SIZE:** _____ **WIDTH:** _____

EYES:
Eye disease or injury.....Y N
Glaucoma.....Y N
Macular Degeneration.....Y N

CARDIOVASCULAR:
High blood pressure.....Y N
Congestive heart failure.....Y N
Heart disease .....Y N
Chest pain/palpitations.....Y N
Swelling feet/ankles/hands.....Y N

EAR/NOSE/THROAT:
Hearing loss/ ringing in ears.....Y N
Sore throat/voice change.....Y N
Swollen glands in neck.....Y N
Seasonal allergies.....Y N

PSYCHIATRIC:
Memory loss/confusion.....Y N
Anxiety.....Y N
Depression.....Y N
Insomnia.....Y N

RESPIRATORY:
Shortness of breath.....Y N
Chronic cough.....Y N
Asthma.....Y N
Emphysema.....Y N

AUTOIMMUNE DISORDERS:
Addison's, Crest Syndrome, HIV, Lupus, PMR,
Rheumatoid Arthritis, Psoriatic Arthritis, Scleroderma,

Other _____

MUSCULOSKELETAL:
Joint pain/stiffness.....Y N
Muscle pain/cramps/weakness.....Y N
Difficulty walking.....Y N
Back pain.....Y N
Numbness/tingling of the
Toes/feet/legs or fingers/hand/arms.....Y N
Osteoarthritis .....Y N

GASTROINSTESTINAL:
Ulcers (gastric, duodenal).....Y N
Reflux.....Y N

ENDOCRINE:
Diabetes.....Y N
Controlled by: Insulin Oral Meds Diet
Thyroid disease .....Y N
Underactive Overactive
Liver disease.....Y N
Kidney disease.....Y N

NEUROLOGICAL:
Headaches/Migraines.....Y N
Seizure/convulsions.....Y N
Tremors/stroke/paralysis.....Y N
Dementia/Alzheimer's disease .....Y N

HEMATOLOGIC/LYMPHATIC:
Anemia.....Y N
Bleeding/bruising problems.....Y N
Phlebitis/blood clots.....Y N

CANCER:
Type:_____
Treatment received:_____
Date of last treatment: _____

Other health issues not mentioned above:

_____

_____

Family history of any illness or disease:

Mother/Father: _____ Brother/sister: _____

Maternal Grandparent: _____ Paternal Grandparent: _____

Alcohol use: Never___ Rarely ___ Occasionally ___ Moderate ___ Daily ___ How much per week: _____

Tobacco: Never smoked ____ Less than 1 pack/day___ 1-2 packs/day ___ If you quit, when: _____

Recreational Drugs: Never ___ Rarely ___ Occasionally ___

Exercise: None ____ Walking ____ Running/jogging ____ Weight training ____ Cycling ____Other: _____

What brings you in to see the doctor today? (Briefly describe the type and duration of the problem)

_____

_____