Raymond J. Abdo, DPM, CWS
St. Louis Foot and Ankle, LLC.

521 N. Virginia Ave.
Eureka, MO 63025
314-849-7600

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:

PAPERWORK FULLY COMPLETED

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

A mask is required at all times while in this medical building. It must cover your nose and mouth at all times.

You will not be called to the exam room if you are on your phone. Cell phones need to be off or on vibrate while you are seeing the physician.

Patients are encouraged to come to the appointment without visitors, but one person will be allowed to accompany the patient to a visit, if needed, to ensure appropriate understanding and implementation of care plans discussed at the visit or to support physical needs of the patient.

Visitors must be healthy with no signs of active illness (no fever, cough, shortness of breath or flu-like symptoms).

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 we can be of any further assistance, please feel free to call the office.

Thank You

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 CIGNA AETNA HEALTHLINK ESSENCE

PRIMARY INSURED NAME: __________________________ DATE OF BIRTH ____________

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.

I have received, or was offered a copy of, the HIPAA Privacy Policy.

PATIENT SIGNATURE ______________________________________ DATE ________________

ST. LOUIS FOOT AND ANKLE, LLC
Raymond J. Abdo, DPM, CWS

HIPAA Compliance Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notices before signing this consent.
The terms of the notice may change. If so, you will be notified at your next visit to update your signature/date.
You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement.
The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.
By signing this form, you consent to our use and disclosure of your protected health information and potentially anonymous usage in a publication. You have the right to revoke the current in writing signed by you. However, such a revocation will not be retroactive.
By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or health care operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The patient has the right to restrict the use of the information but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.
- I have received a copy of the Privacy Practices.

1. May we phone, email, or send a text to you to confirm appointments? YES NO
2. May we leave a message on your answering machine at home or on your cell phone? YES NO
3. May we discuss your medical condition with any other member of your family or other persons? YES NO

I authorize communication with the following person (s):

1.________________________________ ________________________ __________________________
Name Phone number Relationship

2.________________________________ ________________________ __________________________
Name Phone number Relationship

3..________________________________ ________________________ __________________________
Name Phone number Relationship

This consent was signed by:

____
PRINT NAME

Signature:____ Date:_____________ Witness: _______________________

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: ______________

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: ________________

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
Parkinson'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)

____

____