SCOTT H. ANDREW, D.P.M.
Affiliated Foot & Ankle Center, LLC
9030 Montgomery Rd.
Cincinnati, Ohio 45242
Office (513)745-9988
Fax (513)745-0296

Patient name: _____DOB: _____

How were you referred to Affiliated Foot and Ankle Center? _____

Ethnicity/Race: _____ Latino? Y/N Language: _____

Briefly describe your chief complaint:_____

Drug or latex allergies (describe your reactions):_____

_____

Current medications and doses: _____

_____

Do you have any current medical conditions?_____

_____

Do you use:

Tobacco products? How long? How much per day?

_____

Alcohol beverages? Y/N _____

Recreational drugs? Y/N_____

Preferred pharmacy/phone #/location_____

I understand that I will be billed $35.00 for failing to give a 24 hour notice of cancellation for any appointment. (Emergencies and special circumstances are taken into account). Initials _____

I understand that I will be billed $35.00 for returned checks due to insufficient funds. Initials _____.

I understand that I will be charged a $15.00 collection transfer fee if my account is turned over to a collection account agency (balances over 90 days). Initials _____.

I have been offered a copy of the HIPAA (Privacy Information) _____ Date: _____