COMPREHENSIVE MEDICAL AND SURGICAL TREATMENT OF THE FOOT AND ANKLE

Welcome to Acadia Foot and Ankle

Thank you for giving us the opportunity to get you started toward good foot and ankle health.

Please complete the following paperwork in full and **return to our office prior to your appointment. This will allow us to register you for your appointment and place your name on our cancellation list.

Please bring your insurance card(s) to your appointment. We will scan these into our system to allow for proper billing of services you have received. **Payment is expected at the time of service for all co-pays and other charges not covered by your insurance plan. (Co-insurance, Deductibles, and some durable medical equipment, etc.). Payment is also expected for all uninsured (self-pay) patients. If you are covered by an HMO insurance plan, it is your responsibility to obtain the appropriate referral from your Primary Care Physician prior to your appointment with our office.

This office requires all new patients to confirm their appointment at least 48 hours in advance. We will call to remind you of your appointment approximately 2-3 days in advance. If we are unable to reach you, we will leave a message with instructions for you to return our call. **We reserve the right to cancel your appointment if it is not confirmed. If you are unable to keep your appointment for any reason, please call our office to reschedule as soon as possible.

****Please be advised that our office has 10-minute no-show policy. If you arrive 10 or more minutes late for your appointment, we will need to reschedule for another date. As of January 1, 2022 there is a $50 no show fee for all no show/no call appointments.**

PLEASE WEAR A MASK UPON ENTERING OUR OFFICE.

Your appointment is scheduled for _____/_____/_____ with an arrival time of__________________. Our office is located at Evergreen Woods, 700 Mt. Hope Avenue, Suite 620 in Bangor, Maine 04401.

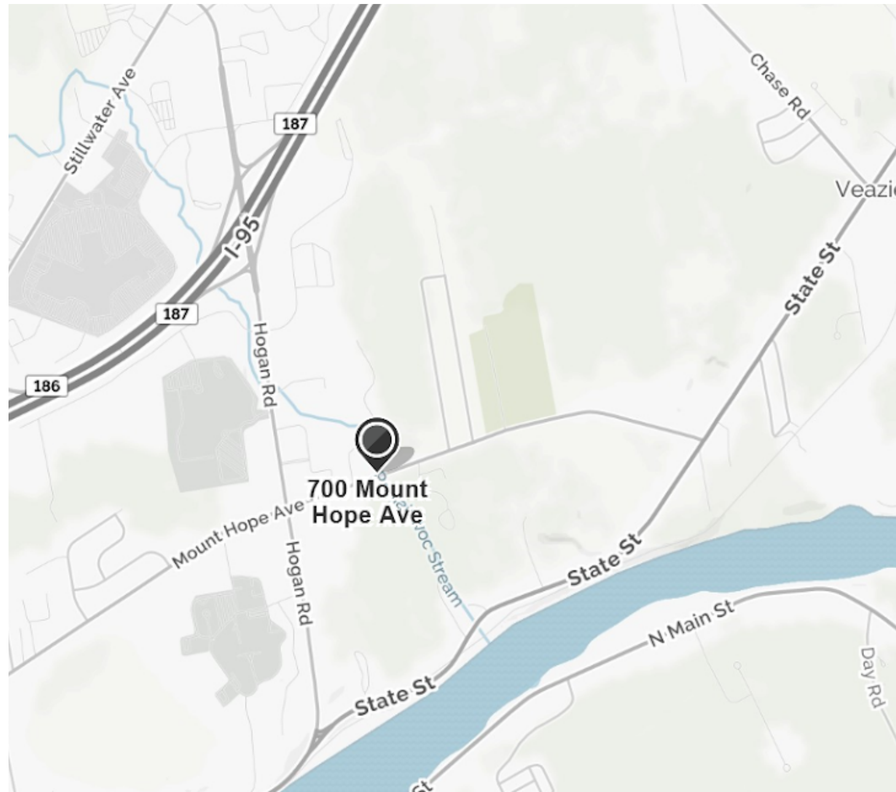
Your appointment is scheduled with:

______Dr. Adam Darcy   ____Dr. Keith Kendall

****Please feel free to call our office with any questions you may have and we are looking forward to meeting you, or seeing you again if you are a returning patient!**

Phone: 207-947-2220   Fax: 207-947-4073

ACADIA FOOT & ANKLE, EVERGREEN WOODS, 700 MT HOPE AVE, SUITE 620, BANGOR



From the North on I-95:
Take exit 187 and turn left onto Hogan Rd. At your 4TH traffic light turn left onto Mt Hope Ave. Drive 0.2 miles and Evergreen Woods, 700 Mt Hope Ave is on your left.
Enter the park and bear right over the bridge, travel to the last building on the left for Suite 620

From the South on I-95:
Take exit 187 and turn right onto Hogan Rd. At your 3RD traffic light turn left onto Mt Hope Ave. Drive 0.2 miles and Evergreen Woods, 700 Mt Hope Ave is on your left.
Enter the park and bear right over the bridge, travel to the last building on the left for Suite 620

From State St:
Travel onto Hogan Rd and at your 1st traffic light turn right onto Mt Hope Ave. Drive 0.2 miles and Evergreen Woods, 700 Mt Hope Ave is on your left.
Enter the park and bear right over the bridge, travel to the last building on the left for Suite 620

From Stillwater Ave:
Travel onto Hogan road and at your 7th traffic light turn left onto Mt Hope Ave. Drive 0.2 miles and Evergreen Woods, 700 Mt Hope Ave is on your left.
Enter the park and bear right over the bridge, travel to the last building on the left for Suite 620

PHONE:207-947-2220

ACADIA FOOT AND ANKLE TODAYS DATE:

NAME: ____DOB: ____________________________

___MALE ___FEMALE

ETHNICITY: ___HISPANIC/LATINO ___ **NOT** HISPANIC OR LATINO ___DECLINE TO SPECIFY

RACE: ___WHITE___AMERICAN INDIAN___ALASKA NATIVE___BLACK/AFRICAN AMERICAN ___ASIAN
___NATIVE HAWAIIAN/PACIFIC ISLANDER ___DECLINE TO SPECIFY

PREFERRED LANGUAGE:______________________________________ SSN:_________/________ /_________

ADDRESS:____
TOWN:________________________STATE______________ZIP CODE_______________

HOME PHONE:____________________CELL PHONE:___________________WORK PHONE:_____________________

EMAIL ADDRESS:____

EMPLOYMENT STATUS: ___EMPLOYED____UNEMPLOYED___FULL TIME STUDENT___RETIRED

PLACE OF EMPLOYMENT:_____________________________________OCCUPATION:________________________

EMERGENCY CONTACT:____________________________________EMERGENCY CONTACT PHONE:__________________
RELATION TO PT:______________________________________

PRIMARY CARE PHYSICIAN:____

DATE OF MOST RECENT OFFICE VISIT WITH YOUR PRIMARY CARE DR:____

REFERRING PHYSICIAN (IF OTHER THAN PRIMARY CARE PHYSICIAN):_______________________________________

PHARMACY AND LOCATION:____

WHO CAN WE SPEAK WITH ABOUT YOUR CARE IN THIS OFFICE: ____
RELATION:____
DO YOU WANT TO BE EXEMPT FROM PUBLIC REPORTING? _____YES ___NO
(NO PERSONAL INFORMATION WILL EVER BE SHARED OR DISCLOSED WITH ANY PUBLIC REPORTING)

INSURANCE INFORMATION: *****PLEASE BRING YOUR INSURANCE CARD(S) TO YOUR APPOINTMENT*****
PRIMARY INSURANCE:____________________________________ ID#:_____________________________
SUBSCRIBER:____SUBSCRIBER DOB:__________________
SUBSCRIBER'S RELATIONSHIP TO INSURED:____________________
SECONDARY INSURANCE:__________________________________ID#:_____________________________
SUBSCRIBER:____SUBSCRIBER DOB:__________________
SUBSCRIBER'S RELATIONSHIP TO INSURED:____________________

REASON FOR YOUR VISIT:____ IS
THIS A WORK-RELATED INJURY? YES_____NO_____HOW LONG HAS THIS BOTHERED YOU?__________________
ON A SCALE OF 1-10 (10 BEING THE WORST) WHAT IS YOUR PAIN LEVEL ________
THE PAIN IS (CIRCLE ALL THAT APPLY) BURNING CONSTANT DULL SHARP SHOOTING THROBBING TINGLING

PATIENT NAME:____**DOB:**________________________

SMOKING STATUS:

________CURRENT EVERY DAY _________CURRENT SOME DAYS _________HEAVY TOBACCO ___________LIGHT TOBACCO

___________# OF PACKS PER DAY ________FORMER SMOKER _______NEVER _________DECLINE TO ANSWER

VITAL SIGNS:

HEIGHT____________________WEIGHT______________________

DID YOU RECEIVE: ___ PNEUMOCOCCAL VACCINE ____ COVID VACCINE _____ FLU SHOT

HAVE YOU COMPLETED ANY ADVANCED DIRECTIVES? ______YES _____NO

CURRENT MEDICATIONS: ____NO KNOWN MEDICATIONS

NAME OF MEDICATION AND STRENGTH: DOSE:

NAME OF MEDICATION AND STRENGTH	DOSE

USE A SEPARATE PIECE OF PAPER IF NEEDED

ALLERGIES:

__NO KNOWN ALLERGIES___NO KNOWN DRUG ALLERGIES

ALLERGY	REACTION:

USE A SEPARATE PIECE OF PAPER IF NEEDED

MEDICAL HISTORY: PLEASE CIRCLE ALL THAT APPLY

LIVER	HEART MURMUR	BLOOD CLOT	ALCOHOLISM	SLEEP APNEA
STOMACH	BOWEL	HIGH CHOLESTEROL	GOUT	BLOOD DISORDERS
DEPRESSION	THYROID DISEASE	DEPRESSION	THYROID DISEASE	CANCER
ALLERGIES	ANXIETY DISORDER	HIGH BLOOD PRESSURE	HEART DISEASE	MENTAL ILLNESS
ASTHMA	BREATHING ISSUES	MUSCULOSKELETAL	HEPATITIS	KIDNEY DISEASE
DIABETES	CIRCULATION PROBLEMS	HEPATITIS	HIV	SKIN DISORDERS
CVA	STROKE	NEUROPATHY:________________	ARTHRITIS:____________________	

OTHER:____

SURGICAL HISTORY: PLEASE CIRCLE ALL THAT APPLY

APPENDECTOMY C-SECTION ANGIOPLASTY BYPASS CATARACTS CHOLECYSTECTOMY (GALL BLADDER REMOVAL)

FEET: ____
PLEASE DESCRIBE

TOTAL KNEE ARTHROPLASTY TOTAL HIP ARTHROPLASTY HEART VALVE

PACEMAKER DEFIBRILLATOR

OTHER: ____

PATIENT NAME:____**DOB:**____________________

SOCIAL HISTORY:

DO YOU DRINK ALCOHOL: ______YES ______NO How many drinks per day:_________________

SUBSTANCE ABUSE:

_____Yes, I currently have a substance abuse problem. Please specify:____

_____No, I have never had a substance abuse problem

EXERCISE:

Do you exercise regularly:

_______Yes, I do the following regular exercise: ____

_______No, I do not exercise regularly

FAMILY HISTORY: Is there any family history **(blood relatives only)** of: **PLEASE INDICATE WHICH FAMILY MEMBER**

Circle all that apply and write family member relation (i.e. mother, father, aunt, uncle, sister, brother, etc) on the line provided

ALZHEIMER'S ___________________________________ DEPRESSION _______________________________________

ARTHRITIS ______________________________________ DIABETES ____

BLEEDING DISORDERS_____________________________ EMPHYSEMA____

BLOOD CLOT_____________________________________ HEART DISEASE _____________________________________

CANCER____ HIGH BLOOD PRESSURE________________________________

CATARACTS______________________________________ NEUROLOGICAL_______________________________________

CIRCULATION ISSUES _____________________________ STROKE____

OTHER: ____

REVIEW OF SYSTEMS: PLEASE CIRCLE ALL THAT APPLY OR CIRCLE NONE IF NOTHING APPLIES FOR EACH CATEGORY

CARDIOVASCULAR	LEG PAIN WHEN WALKING	FAINTING	CHEST PAIN/PRESSURE	LEG SWELLING			
	COLD HANDS/FEET	VASCULAR DISEASE	VALVE PROBLEMS	PALPITATIONS			**NONE**
GENITOURINARY	BLOOD IN URINE	HESITANCY	INCONTINENCE	INCREASED URGENCY			
	DECREASED FREQUENCY	EXCESSIVE URINATION	KIDNEY DISEASE	KIDNEY STONES			**NONE**
GASTROINTESTINAL	ABDOMINAL PAIN	HEARTBURN	BLOOD IN STOOL	VOMITING	ULCERS	CONSTIPATION	
	DIARRHEA	DIFFICULTY SWALLOWING	DECREASED APPETITE	INCREASED APPETITE			**NONE**
INTEGUMENTARY (SKIN)	ATHLETES FOOT	NAIL ABNORMALITIES	KELOIDS	ITCHY	DRY/SCALY SKIN		**NONE**
HEMATOLOGIC	LOWER LEG ULCERS	SICKLE CELL DISEASE	ANEMIA	BLOOD THINNERS	CLOTTING DISORDERS		**NONE**
NEUROLOGICAL	TINGLING	WEAKNESS	SEIZURES	NUMBNESS	HEADACHES	TREMORS PARALYISIS	**NONE**
MUSCULOSKELETAL	BACK PAIN	JOINT SWELLING	JOINT STIFFNESS	JOINT WEAKNESS	JOINT INSTABILITY	SCIATICA ARTHRITIS	
	NECK PAIN	MUSCLE PAIN	MUSCLE WEAKNESS				**NONE**
RESPIRATORY	CHEST PAIN	WHEEZING	COPD	COUGHING	SNORING	SHORTNESS OF BREATH EMPHYSEMA	**NONE**

PLEASE READ AND SIGN: The information on these intake forms is correct to the best of my knowledge. I understand that throughout my treatment I am responsible for notifying the physician and/or medical staff of any and all updates to the information listed above. (*Assignment of Benefits*): I authorize payment of medical benefits to the practice named above. (*Release of Information*): I authorize the release of any medical information necessary to process this claim. (*HIPPA Privacy*): I acknowledge that I received my HIPPA Privacy Practice Notices. (*Medication History)*: I authorize this medical practice to retrieve my medications history.

Patient Signature:____Date:______________________________

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DSICLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this notice while it is in effect. This Notice takes effect on 4/14/03, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy and the new term of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy policies, or for copies of this Notice, please contact us using the information listed at the end of this Notice.

Required by Law: We may use or disclose your health information when we are required to do so by law.

USES AND DISCLOSURES OF HEALTH INFORMATION
We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certifications, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice.
We may disclose your health information to a family member, friend, or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.