ADVANCED FOOT SPECIALISTS, LLC

ROSANNE CLEMENT, DPM
JEFFREY OSBOURNE, DPM

3870 South 108th Street
Greenfield, WI 53228
Telephone (414) 327-2770
Fax (414) 327-0338

331 East Puetz Road, Suite 105
Oak Creek, WI 53154
Telephone (414) 768-9933
Fax (414) 768-9936

Dear Patient,

Thank you for scheduling an appointment with Advanced Foot Specialists.

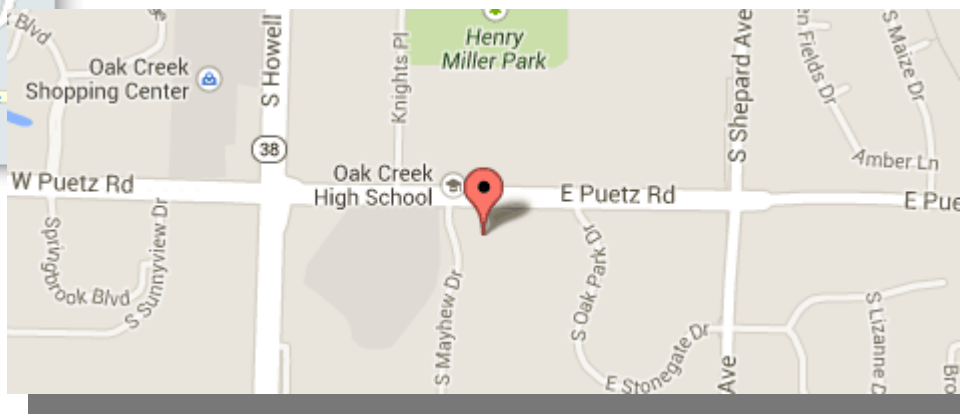
If you need to cancel or change your appointment, please notify us at least 24 hours in advance by calling (414) 327-2770.

Please bring the following to your appointment:

1. Completed new patient paperwork
2. Medical Insurance card
3. Insurance co-pay (we accept cash, check or credit card)
4. Medication and allergy list (if applicable)

Please arrive **15** minutes prior to your appointment time. For more information, please visit our website: advancedfoot.net

Greenfield location is located on the NE corner of 108th and Howard. One block south of Beloit Road.



Oak Creek location is located one block east of Howell on Puetz in the Aurora Medical Building.

ADVANCED FOOT SPECIALISTS, LLC

PATIENT INFORMATION

NAME_____**MARITAL STATUS**_____

ADDRESS_____

CITY_____**STATE**_____**ZIP:**_____

PHONE: (_____**)**_____**AGE:**_____**DATE OF BIRTH**___/___/___

EMAIL ADDRESS:_____

OCCUPATION: _____**EMPLOYER:**_____

WORK PHONE: (_____**)**_____**CELL PHONE: (**_____**)**_____

INSURANCE INFORMATION

INSURANCE CO: _____ **2ND INSURANCE**_____

NAME OF INSURED_____ **NAME OF INSURED**_____

D.O.B. OF INSURED: ___/___/___ **D.O.B. OF INSURED** ___/___/___

ID#:_____ **ID#:**_____

GROUP #:_____ **GROUP#:**_____

PRIMARY CARE DOCTOR: first name: _____**last name:** _____

PRIMARY DOCTOR PHONE: (_____**)**_____

PHARMACY NAME:_____**CITY/CROSSSTREETS**_____**PHONE**_____

***WE WILL FILE INSURANCE FORMS FOR YOU. HOWEVER, BECAUSE OF SO MANY DIFFERENT INSURANCE COMPANIES AND POLICIES, WE FEEL THAT IT IS YOUR RESPONSIBILITY TOKNOW AND/OR TO FIND OUT WHAT YOUR INSURANCE COVERS
AND WHAT MAY BE IN QUESTION, SUCH AS ORTHOTIC DEVICES, SURGERY, POST-OPERATIVE CARE AND PHYSICIAN THERAPY. **IT IS YOUR RESPONSIBILITY**, TO FOLLOW THROUGH **WITH YOUR INSURANCE** COMPANY SHOULD PAYMENT BE OVER DUE OR NON-PAYABLE.
***IT IS YOUR RESPONSIBILITY**, WHEN YOU HAVE AN INSURANCE COMPANY THAT REQUIRES REFERRALS, TO KEEP TRACK OF AMOUNTS OF VISITS ALLOWED AND USED, AND ALSO THE TIME IN WHICH THEY ARE VALID. IF TIME HAS ELAPSED OR VISITS HAVE BEEN USED UP, YOU WILL BE BILLED FOR CARE.

SIGNATURE: _____**DATE:**_____

ADVANCED FOOT SPECIALISTS, LLC

MEDICAL HISTORY

NAME: _____

WEIGHT_____ **HEIGHT**_____ **SHOE SIZE**_____ **SHOE WIDTH**_____

RACE: ❑WHITE ❑AFRICAN AMERICAN ❑HISPANIC ❑ASIAN ❑OTHER: _____

PLEASE DESCRIBE THE REASON FOR YOUR VISIT TODAY? _____

_____

HAVE YOU SEEN A PODIATRIST BEFORE? ❑ YES ❑ NO

IF YES, STATES THE REASON: _____

_____

DO YOU SMOKE? ❑ YES ❑ NO

(CHECK ONE) ❑ CURRENT SMOKER ❑ FORMER SMOKER ❑ NEVER SMOKED

ARE YOU PREGNANT? ❑ YES, DUE DATE: _____ ❑ NO

LIST ANY MEDICATIONS YOUR TAKING: IF NONE, PLEASE CHECK BOX ❑

_____

_____

_____

LIST ANY MAJOR SURGERIES OR HOSPITALIZATIONS YOU HAVE HAD? (Please be specific)
IF NONE, PLEASE CHECK BOX ❑

_____

_____

DO YOU HAVE AN EMERGENCY CONTACT? ❑ YES ❑ NO

NAME: _____

PHONE: (_____) _____RELATIONSHIP_____

I HEREBY STATE THAT THE ABOVE INFORMATION IS ACCURATE AND CORRECT TO THE BEST OF MY KNOWLEDGE. I ALSO HEREBY REQUEST AND AUTHORIZE THE DOCTOR TO DIAGNOSE AND ADMINISTER TREATMENT FOR MY FOOT CONDITION.

SIGNATURE: _____**DATE:**_____

ADVANCED FOOT SPECIALISTS

MEDICAL HISTORY

PLEASE IDENTIFY ANY ALLERGIES OR SENSITIVITIES

( ) PENICILLIN	**( ) ANESTHETICS**	**( ) ASPIRIN**
( ) SULFA	**( ) IODINE**	**( ) ADHESIVES**
( ) NOVOCANE	**( ) CODEINE**	**( ) ANTIBIOTIC_____**
( ) FOODS	**( ) LATEX**	**( ) NONE**

( ) OTHER (please specify)_____

HAVE YOU EVER HAD?

( ) HEART TROUBLE	**( ) PROLONGED BLEEDING**
( ) HIGH BLOOD PRESSURE	**( ) BLOOD DISEASE**
( ) CIRCULATION PROBLEMS	**( ) EPILEPSY**
( ) RAYNAUD'S DISEASE	**( ) THYROID DISEASE**
( ) KIDNEY DISEASE	**( ) STOMACH ULCERS**
( ) VARICOSE VEINS	**( ) RHEUMATIC FEVER**
( ) HEPATITIS/LIVER DISEASE	**( ) HIV (AIDS)**
( ) ARTIFICIAL JOINTS OR VALVE	**( ) ANEMIA**
( ) LUNG/BREATHING DISORDERS	**( ) ARTHRITIS**
( ) CANCER	**( ) DIABETES**
( ) GOUT	**( ) ASTHMA**
( ) DEPRESSION	**( ) PSYCHOLOGICAL DISORDER**
( ) ANXIETY	**( ) CHRONIC PAIN MANAGEMENT**
( ) OTHER_____	**( ) NONE**

How did you hear about us? AD___ FRIEND___ INTERNET___ DOCTOR___ INSURANCE___OTHER____

I HEREBY STATE THAT THE ABOVE INFORMATION IS ACCURATE AND CORRECT TO THE BEST OF MY KNOWLEDGE. I ALSO HEREBY REQUEST AND AUTHORIZE DR. ROSANNE CLEMENT, DR. JEFFREY OSBOURNE TO DIAGNOSE AND ADMINISTER TREATMENT FOR MY FOOT CONDITION.

SIGNATURE: _____DATE:_____

ADVANCED FOOT SPECIALISTS LLC

Notice of Privacy Practices

I acknowledge that I was offered a copy of the NOTICE OF PRIVACY PRACTICES. I have read and or been given the opportunity to review the notice.

******* COPIES OF THE PRIVACY NOTICE ARE LOCATED ON THE TABLE IN THE LOBBY**

PATIENT NAME: _____ DATE: _____

PATIENT SIGNATURE: _____

FOR PATIENTS UNDER 18;

If you are a **PARENT** or an **AUTHORIZED REPRESENTATIVE** for the patient please sign below.

RELATIONSHIP TO PATIENT: **_____**

SIGNATURE: _____ DATE: _____