FOOT AND ANKLE PHYSICIANS WEST

Name:_____ **M F Age:**_____
First Middle Initial Last

Address:_____
Street City State Zip Code

Phone: (___)_____ **Cell Phone:**(___)_____ **Date of Birth:**_____

Email:_____ **Weight:** _____ **Height:**_____ **Shoe Size:**_____

Race (circle one) American Indian or Alaskan Native Asian Black or African American Native Hawaiian or Other Pacific Islander White

Ethnicity (circle one) Hispanic or Latino Not Hispanic or Latino

Primary language if other than English:_____

Policyholder's name:_____ **Policyholder's Date of Birth:**_____

Emergency Contact Person:_____
Name Phone

How did you hear about our clinic? (circle one)
Internet Insurance Company Phone Book Other (specify)_____

Assignments of Benefits: I authorize all medical benefits to be paid directly to Foot and Ankle Physicians West. I hereby authorize Foot and Ankle Physicians West to release to my insurance company, health plan, HMO, no-fault carrier and/or workers' compensation carrier, any information, including my complete health record, needed to determine benefits for services provided by or on behalf of Foot and Ankle Physicians West. I am responsible for all services paid by the insurance company. If my account becomes delinquent, I agree to pay collection costs, attorney's fees, interest, any costs associated with placing my account with a collection agency and/or to an attorney for litigation. I authorize Foot and Ankle Physicians West to release medical information about me to my referring physician.

_____
Signature Date

Medicare Patients: I request payment of Medicare payments be made directly to Foot and Ankle Physicians West for any services furnished to me by that organization. I authorize the release of information about my care HCFA and its agents.

_____
Signature Date

Foot & Ankle Physicians West

PAST HISTORY: Have you ever had:

Anemia	yes	no
Anxiety	yes	no
Arthritis	yes	no
Asthma	yes	no
Autoimmune disease	yes	no
Specify _____		
Back problems	yes	no
Bleeding tendency	yes	no
Broken bones	yes	no
Where_____		
Bronchitis	yes	no
Cancer	yes	no
Type_____		
Depression	yes	no
Diabetes	yes	no
Type I or Type II (circle)		
Last hemoglobin A1c_____		
Emphysema	yes	no
Epilepsy/Seizures	yes	no
Gout	yes	no
HIV	yes	no
Heart disease	yes	no
Hepatitis B or C	yes	no
High blood pressure	yes	no
High cholesterol	yes	no
Kidney Disease	yes	no
Liver disease	yes	no
MRSA	yes	no
Peripheral Vascular Disease	yes	no
Polio	yes	no
Stroke/TIA	yes	no
Thyroid problems	yes	no
Tuberculosis	yes	no
Ulcers	yes	no
Other:	yes	no
Specify_____		

ALLERGIES:

Anesthetics	yes	no
Anti-inflammatory Drugs	yes	no
Aspirin	yes	no
Codeine	yes	no
Cortisone	yes	no
Erythromycin	yes	no
Iodine	yes	no
Latex	yes	no
Penicillin	yes	no
Sulfa	yes	no
Tape/adhesives	yes	no
Other	yes	no
Specify_____		

Name_____
Date of birth_____

PRIMARY CARE DOCTOR and CLINIC:

_____

Date of last exam:_____

MEDICATIONS:

Name of medication Dosage

_____

_____

_____

_____

SURGERIES:

Foot/leg	yes	no
Back	yes	no
Heart	yes	no
Hip	yes	no
Joint replacement	yes	no
Other:	yes	no
Specify_____		

SOCIAL HISTORY:

Marital status: (circle)

Married Single Widowed Divorced Separated Partnered

Who do you live with?_____

Do you smoke?	yes	no
# per day_____		
Are you a former smoker?	yes	no
Do you use tobacco products?	Yes	no
Do you drink alcohol?	yes	no
# per week_____		
Do you drink caffeinated beverages?	yes	no
# per day_____		

Occupation:_____

Employer:_____

Hobbies and Recreational activities:_____

_____

FAMILY HISTORY:	**Mother**		**Father**	
Arthritis	yes	no	yes	no
Bunions	yes	no	yes	no
Cancer	yes	no	yes	no
Diabetes	yes	no	yes	no
Gout	yes	no	yes	no
Heart Disease	yes	no	yes	no
High blood pressure	yes	no	yes	no
Kidney disease	yes	no	yes	no
Liver disease	yes	no	yes	no
Lung disease	yes	no	yes	no
Stroke	yes	no	yes	no

Unknown ☐

Name:_____

Circle any of the following symptoms you have had in the past 6 months.

Fatigue	Fever	Night sweats
Weight gain	Weight loss	Chest pain/pressure
Heart palpitations	Cellulitis	Keloid
Psoriasis	Rash	Redness
Sores	Warmth	Excessive thirst
Obesity	Abdominal pain	Constipation
Diarrhea	Heartburn	Nausea
Vomiting	Kidney failure	Pregnancy
Bleeding	Blood clots	Bruising
Back pain	Bone pain	Joint locking
Joint pain	Decreased range of motion	Muscle pain
Muscle weakness	Neck pain	Osteoporosis
Shooting pain	Swelling	Gait abnormality
Numbness and tingling	Alcohol abuse	Drug use
Anxiety	Depression	Stress
Emphysema	Shortness of breath	Wheezing
		NONE

FEMALE PATIENTS:

Are you pregnant? yes no

Due date_____

Are you breastfeeding? yes no

PATIENT CONSENT FORM

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been informed by you of your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such *Notice of Privacy Practices* prior to signing this consent. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time, and that I may contact this organization at any time at the address indicated to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time except to the extent that you have taken action relying on this consent.

Patient name:_____

Signature:_____

Relationship to patient:_____

Date:_____