

PATIENT INFORMATION

PATIENT INFORMATION (PLEASE PRINT)

LEGAL NAME _____
FIRST MI LAST

ADDRESS _____

CITY _____ STATE _____ ZIP _____

PHONE (____) _____ CELL PHONE (____) _____

MALE _____ FEMALE _____ BIRTH DATE _____ AGE _____

MARITAL STATUS: MARRIED _____ SINGLE _____ DIVORCED _____ WIDOWED _____ OTHER _____

SOCIAL SECURITY # _____ E-MAIL ADDRESS _____

HOW DID YOU HEAR ABOUT OUR OFFICE? _____

FAMILY DOCTOR _____ PHONE _____

EMERGENCY CONTACT _____ RELATIONSHIP _____

HOME PHONE (____) _____ WORK PHONE _____

PATIENT'S EMPLOYER

RETIRED? YES/NO STUDENT? FULLTIME/ PART-TIME/NO

EMPLOYER _____ JOB TITLE _____

PHONE (____) _____ EXTENTION _____

HEALTH INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY _____

PRIMARY NAME ON CARD _____ REL. TO PATIENT _____

ADDRESS _____ CITY _____ ST _____ ZIP _____

DATE OF BIRTH _____ SOCIAL SECURITY NUMBER _____

EMPLOYER: _____ WORK PHONE _____ EXT _____

HEALTH INSURANCE INFORMATION CONTINUED

SECONDARY INSURANCE COMPANY _____

PRIMARY NAME ON CARD _____ REL. TO PATIENT _____

ADDRESS _____ CITY _____ ST _____ ZIP _____

DATE OF BIRTH _____ SOCIAL SECURITY NUMBER _____

EMPLOYER: _____ WORK PHONE _____ EXT _____

WORKERS COMP INFORMATION

IS THIS A WORK RELATED ACCIDENT? YES / NO IF YES, DATE OF INJURY _____

IF YES, CLAIM NUMBER _____

AUTO/PERSONAL RELATED ACCIDENT? YES/NO

IF ACCIDENT, RESPONSIBLE PARTY: _____

NAME: _____

ADDRESS: _____

CITY _____ **STATE** _____ **ZIP** _____

CONTACT PERSON: _____

HIPPA COMPLIANCE

May we mail correspondence to your home address? Yes/No

May we leave detailed messages at your home number? Yes/No

May we leave detailed messages at your work number? Yes/No

I CERTIFY THE INFORMATION PROVIDED ON THIS FORM IS CORRECT TO THE BEST OF MY KNOWLEDGE. I ALSO UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT COVERED BY INSURANCE. I AGREE TO BE HELD RESPONSIBLE FOR COLLECTION PROCESSING FEES, WHICH MAY BE ADDED TO MY ACCOUNT IF COLLECTION ACTION OCCURS. I AUTHORIZE THE RELEASE OF MEDICAL INFORMATION NECESSARY TO PROCESS CLAIMS. I AUTHORIZE THE RELEASE OF MEDICAL INFORMATION TO MY PRIMARY CARE PHYSICIAN AND TO ANY OUTSIDE FACILITY THAT IS ASSISTING WITH MY CARE, SUCH AS PHYSICAL THERAPY AND MRI FACILITES

SIGNATURE _____ **DATE** _____
IF MINOR, PARENT OR GUARDIAN PLEASE SIGN

I CERTIFY THAT I HAVE BEEN GIVEN THE OPPORTUNITY TO REVIEW THE REGULATIONS ON PATIENT PRIVACY LAWS IN THE FORM OF THE HIPAA OUTLINE PROVIDED BY MY PHYSICIAN.

SIGNATURE _____ **DATE** _____
IF MINOR, PARENT OR GUARDIAN PLEASE SIGN

For practice use only

Practice:	Accepts	Declines
Privacy Officer Signature:	_____	
Date:	_____	

NAME: _____ DATE: _____

PATIENT INFORMATION

MEDICATIONS: _____

_____ **NO KNOWN DRUG ALLERGIES**

ALLERGIES TO MEDICATIONS/REACTIONS

PERSONAL PAST MEDICAL HISTORY : (Please X if you have these.)

Allergic/Immunologic

__seasonal allergies

__environmental allergies

Other allergies:

Cardiovascular

__Congestive heart failure

__Murmur

__Deep Vein Thrombosis

__Rheumatic

__General Cardiovascular Problems

__Stroke

__Heart Disease

__Calf cramping

__High Blood Pressure

__Low Blood Pressure

__High Cholesterol

Dermatologic/Skin

__Candidiasis (yeast infection)

__Skin Cancer

__Cellulitis

__Psoriasis

__Warts

__Fungal Infections

__Athlete's foot

__Cysts

__Itchy/ Dry Skin

__Raynaud's phenomenon

__Lower leg ulcers

__Leg swelling

__Skin discoloration

Endocrine

__Diabetes _____Onset

_____Average blood sugar

__Type I

__Type II

__Hypoglycemia

__Obesity

__Menopause

__Hypothyroidism (low thyroid)

__Hyperthyroidism (high thyroid)

Genetic Background

__Autism

__Cystic Fibrosis

__Muscular dystrophy

Gastric/ Intestines

__Cancer

__Diverticulitis

__GI bleed

__Colitis

__GERD/heartburn

__Liver conditions

__Crohn's

__Gastritis

__Stomach or bowel problems

NAME: _____ DATE: _____

Genitourinary

Bladder dysfunction Kidney problems Dialysis

HEENT Hx

Allergic Rhinitis Ear conditions Nasal/sinus conditions
 Eye conditions Throat conditions

Hematological

Anemia Hemophilia Lymphoma
 Leukemia Bleeding abnormalities Bruise easily
 HIV/AIDS Hepatitis __A __B __C

Musculoskeletal

Amputation Ganglion Osteomyelitis
 Osteoarthritis Rheumatoid Arthritis Gout
 Osteoporosis Neoplasm Back pain
 Knee pain Neck pain Hip pain
 Muscle pain Joint pain Fracture History _____

Neurological History

Alzheimer's Multiple Sclerosis Seizure Disorder
 Aneurysm Neurofibromatosis Sciatica
 Migraines Neuropathy Cerebral Palsy

Pregnancy (if applicable)

currently pregnant How many weeks? __
 not pregnant

Respiratory

Asthma Emphysema Pneumonia
 COPD Lung Cancer Tuberculosis
 Chest pain Difficulty breathing Sleep Apnea

Psychiatric

Depression Bi Polar Dementia
 Anxiety Disorder Mental Health disorder Other

OTHER, please list _____

Past Surgical History (type of surgery and year surgery was performed)

Social History

Do you smoke? _____ Yes _____ No How Much _____ How Long _____

Do you drink alcohol? _____ Yes _____ No How Much _____ How Long _____

What type of job do you have? _____

NAME: _____ DATE: _____

FAMILY HISTORY: Maternal(Mother) / Paternal(Father)

M__ F__ Alcoholism

M__ F__ Diabetes

M__ F__ Anesthesia Problems

M__ F__ Heart Problems

M__ F__ Arthritis

M__ F__ Neurological Disorder

M__ F__ Cancer

M__ F__ Respiratory

M__ F__ Cystic Fibroses

M__ F__ Seizures

PLEASE READ AND SIGN

The above information is correct to the best of my knowledge.

I understand that I am responsible for any charges incurred during any visit or treatment by the doctors and staff of Clintonville/Dublin Foot & Ankle. My insurance company may not cover my charges for the following reasons: I did not bring a referral for this care, the referral did not arrive in time for the visit, my insurance company may not cover the service, my insurance may not be in effect, the charges maybe applied to my deductible/co pay. The doctors and staff of Clintonville/Dublin Foot & Ankle will file my insurance when appropriate, but I will be ultimately responsible for all charges. A fee schedule can be obtained up on request. I understand that payment is due at the time of service with no insurance or for non-covered services.

Patient/Parent/Guardian

Date