PATIENT INFORMATION (PLEASE PRINT) **DATE**_____

LEGAL NAME_____
FIRST MI LAST

BIRTH DATE _____ AGE _____ MALE _____ FEMALE _____

ADDRESS_____

CITY _____ STATE _____ ZIP _____

HOME # _____ CELL # _____ WORK # _____

WHAT IS THE BEST NUMBER TO CONTACT YOU DURING THE DAY? HOME _____ CELL _____ WORK _____

MARITAL STATUS: MARRIED____ SINGLE____ DIVORCED____ WIDOWED____ OTHER _____

RACE: _____ HISPANIC? YES/ NO LANGUAGE _____

SOCIAL SECURITY # _____ E-MAIL ADDRESS_____

HOW DID YOU HEAR ABOUT OUR OFFICE? _____

FAMILY DOCTOR _____PHONE_____

EMERGENCY CONTACT _____ RELATIONSHIP _____

HOME PHONE (____)_____ CELL PHONE _____

PATIENT'S EMPLOYER

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

EMPLOYER _____ JOB TITLE _____

HEALTH INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY _____

POLICY HOLDER NAME _____ POLICY HOLDER BIRTHDATE _____

SECONDARY HEALTH INSURANCE (IF APPLICABLE)

SECONDARY INSURANCE COMPANY _____

POLICY HOLDER NAME _____POLICY HOLDER BIRTHDATE _____

PHARMACY

PHARMACY NAME _____

PHONE _____

ADDRESS _____

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/ Not applicable

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

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:_____ DOB:_____ Date: _____

Current Medications:

_____ _____

_____ _____

_____ _____

_____ _____

Drug Allergies: _____

Other Allergies: _____

Are you pregnant? Yes / No Weeks:_____

Personal Medical History

- ▫ Congestive heart failure
- ▫ Blood clots
- ▫ High blood pressure
- ▫ Heart attack
- ▫ Stroke
- ▫ Irregular heart beat
- ▫ Cancer
- ▫ Diabetes __type I __ type II
- ▫ Hypothyroidism
- ▫ Hyperthyroidism
- ▫ Autism
- ▫ Cystic fibrosis
- ▫ GI bleed
- ▫ Stomach / Bowel problems
- ▫ Kidney Disease or Dialysis
- ▫ HIV / AIDS
- ▫ Anemia
- ▫ Hepatitis __A __B __C
- ▫ Bleed/bruise easily
- ▫ Osteoarthritis
- ▫ Gout
- ▫ Rheumatoid arthritis
- ▫ Alzheimer's
- ▫ Seizures
- ▫ Aneurysm
- ▫ Pulmonary embolism
- ▫ COPD
- ▫ Asthma
- ▫ Emphysema
- ▫ Sleep apnea
- ▫ Mental illness
- ▫ Alcohol / Drug addiction
- ▫ Other:

Family History: M (Mother) / F (Father)

M	F	
▫	▫	Anesthesia Problems
▫	▫	Arthritis
▫	▫	Cancer
▫	▫	Diabetes
▫	▫	Heart Problems
▫	▫	Neurological Disorder
▫	▫	Respiratory Disorder
▫	▫	Seizures

Prior Surgical History (please list procedure and year it was performed)

_____

_____

_____

Name:_____ Date:_____

Height:_____ Weight:_____ Shoe Size:_____ Are you diabetic? Yes / No

Do you drink alcohol? Yes / No How much: _____

Do you smoke? Yes / No How much? _____ How many years? _____

Occupation: _____

What is the main reason for seeing one of our physicians today? _____

_____

Duration of pain: _____ Symptoms: _____

Is this related to an injury? Yes / No

If yes, please describe:_____

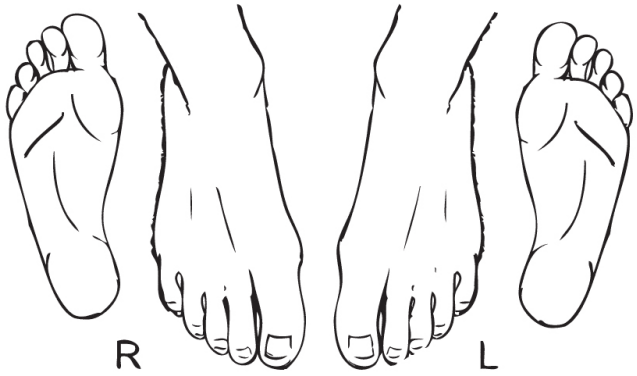
Please mark any treatments you have tried: ___Custom Orthotics ___Physical Therapy

___Anti-inflammatory Medications ___Injections ___Prior Surgery

___Seeing Another Doctor ___Braces ___No Treatment

___Other_____

Please mark on the diagram where you are experiencing pain and or symptoms



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 may be applied to my deductible/co pay. The doctors and staff of Clintonville/Dublin Foot & Ankle will file my insurance when appropriate, but I will ultimately be responsible for all charges. A fee schedule can be obtained upon request. I understand that payment is due at the time of service with no insurance or for non-covered services.

_____ _____

Patient/Parent/Guardian Signature Date