Foot and Ankle Clinic P.A

Jeff Pellersels, DPM Carly Kriedberg, DPM Roy Moeller, DPM

Full Name: _____
(First) (Middle) (Last)
Address: _____

Date of Birth: _____ Height: _____ Weight: _____ Sex: [ ] F [ ]M

Home Phone: _____ Cell Phone: _____
Email: _____ Marital Status: [ ] M [ ]P [ ]S [ ]D [ ]W
Race/ Ethnicity:
[ ] American Indian / Alaskan Native [ ] Asian [ ]White/Caucasion
[ ] Black / African American [ ] Native Hawaiian [ ] Hispanic / Latino

Emergency Contact:_____
(Name) (Phone Number) (Relationship)

How did you hear about our clinic: Internet / TV / Insurance Company / Other:_____
Patient Occupation/Employer:_____
Insurance Policy Holder Name: _____
Policy Holder's Date of Birth:_____

Assignment of Benefits: I authorize all medical benefits to be directly paid to Foot and Ankle Clinic PA. I hearby authorize Foot & Ankle Clinics to release to my insurance company, health plan, HMO, no fault carrier, and/or workers compensation carrier my complete health record needed to determine benefits for services provided at Foot & Ankle Clinic. I am responsible for all services paid by the insurance company. Should I become delinquent I agree to pay collection costs, attorney's fees, interest, any any cost associated with my account being placed in collections and/or attorney litigation. I authorize Foot & Ankle Clinic to release my information to my primary care or referring physician.

Signature: _____ Date: _____

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

Signature: _____ Date: _____

HEALTH HISTORY

Primary Care Physician/Clinic: _____
Referring Physician/Clinic: _____
Date of Last Physical Exam: _____

SOCIAL HISTORY

Do you smoke : [ ] Y [ ] N
If yes, how any packs do you smoke: _____ Are you a former smoker? [ ]Y [ ]N
Do you drink alchohol? If yes, how many drinks a week? _____
Do you have any hobbies and recreational activities: _____
Females Patients Only:
Are you pregnant? Yes / No
If yes, are you currently breast feeding? Yes / No

MEDICATIONS please list any medications you are currently taking

_____
_____
_____
_____
_____

PAST HISTORY Have you ever had:

Anemia	**Yes**	**No**	**Anxiety**	**Yes**	**No**
Arthritis	**Yes**	**No**	**Asthma**	**Yes**	**No**
Autoimmune Disease (if yes, please specify) _____	**Yes**	**No**	**Broken Bones (if yes, please specify) _____**	**Yes**	**No**
Back Problems	**Yes**	**No**	**Bronchitis**	**Yes**	**No**
Cancer (if yes, please specify) _____	**Yes**	**No**	**Diabetes (if yes, please specify) _____**	**Yes**	**No**
Depression	**Yes**	**No**	**Emphysema**	**Yes**	**No**
Epilepsy/Siezures	**Yes**	**No**	**Gout**	**Yes**	**No**
HIV/AIDS	**Yes**	**No**	**Heart Disease**	**Yes**	**No**

Hepatitis B	**Yes**	**No**	**Hepatitis C**	**Yes**	**No**
High Blood Pressure	**Yes**	**No**	**High Colesterol**	**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 (if yes, please specify) _____**	**Yes**	**No**

ALLERGIES

Anesthetics	**Yes**	**No**	**Anti-Inflamatory Drugs**	**Yes**	**No**
Asprin	**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 (if yes, please specify) _____**	**Yes**	**No**

HAVE YOU EXPERIENCED ANY OF THESE SYMPTOMS IN THE PAST 6 MONTHS?

Fatigue	**Yes**	**No**	**Fever**	**Yes**	**No**
Weight Gain	**Yes**	**No**	**Weight Loss**	**Yes**	**No**
Heart Palpitations	**Yes**	**No**	**Chest Pain/Pressure**	**Yes**	**No**
Psoriasis	**Yes**	**No**	**Callulitis**	**Yes**	**No**
Keloid	**Yes**	**No**	**Rash**	**Yes**	**No**
Redness	**Yes**	**No**	**Sores**	**Yes**	**No**
Warmth	**Yes**	**No**	**Excessive Thirst**	**Yes**	**No**
Obesity	**Yes**	**No**	**Abdominal Pain**	**Yes**	**No**

Constipation	**Yes**	**No**	**Diarrhea**	**Yes**	**No**
Heartburn	**Yes**	**No**	**Nausea/Vomiting**	**Yes**	**No**
Kidney Disease	**Yes**	**No**	**Liver Disease**	**Yes**	**No**
Bleeding	**Yes**	**No**	**Blood Clots**	**Yes**	**No**
Bruising	**Yes**	**No**	**Back Pain**	**Yes**	**No**
Bone Pain	**Yes**	**No**	**Joint Locking**	**Yes**	**No**
Joint Pain	**Yes**	**No**	**Decreased Range of Motion**	**Yes**	**No**
Muscle Pain	**Yes**	**No**	**Muscle Weakness**	**Yes**	**No**
Neck Pain	**Yes**	**No**	**Osteoporosis**	**Yes**	**No**
Shooting Pain	**Yes**	**No**	**Swelling**	**Yes**	**No**
Abnormal Gait	**Yes**	**No**	**Numbness/Tingling**	**Yes**	**No**
Alcohol Abuse	**Yes**	**No**	**Drug Use**	**Yes**	**No**
Anxiety/Stress	**Yes**	**No**	**Depression**	**Yes**	**No**
Emphysema	**Yes**	**No**	**Shortness of Breath**	**Yes**	**No**

FOOT & ANKLE CLINICS P.A.

Notice of Privacy Practices

This notice describes how the medical information about you may be used and disclosed. Please review and sign the acknowledgement.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by Foot and Ankle Clinics, P.A. are kept confidential.

As required by HIPAA, we have summarized how we intend to maintain the privacy of your personal health information (PHI).

We may use and disclose your medical records for the following purposes: Treatment, Payment and Health Care Operations.

- **Treatment** may require that your information be disclosed to other health professionals who are involved in your care such as specialists to whom you have been referred.
- **Payment** includes such activities as submitting claims to your insurance company for reimbursement, confirming eligibility or utilization review.
- **Health Care Operations** include the business aspects of running our practice such as internal quality review, auditing functions or cost management analysis.

We may also contact you by phone, voicemail or mail to provide you with appointment reminders or information regarding your treatment.

Any other use and disclosure of your health information will be made only with your written authorization unless already authorized by law.

You have the following rights with respect to your protected health information (PHI):

- The right to reasonable requests to receive confidential communication of your PHI
- The right to inspect and copy your PHI
- The right to receive an accounting of disclosures of your PHI
- The right to request an amendment of your PHI

This NOTICE OF PRIVACY PRACTICES is effective April 1, 2003 and will remain in effect unless changed by law. We are required to abide by its terms. If you feel your privacy protections have been violated, you have the right to file a formal, written complaint and forward it to the attention of the Privacy Officer at any of our clinic locations.

I have read and understand the NOTICE OF PRIVACY PRACTICES of Foot and Ankle Clinics, P.A.

Signed _____ Date _____

Patient Name (Print) _____ Date of Birth _____