SHORELINE FOOT & ANKLE ASSOCIATES, PC

PATIENT HISTORY

PATIENT: _____ **DATE:** _____

BIRTH DATE: _____ **Patient's SSN #:** _____

MALE: _____ **FEMALE:** _____ **Marital Status: M S W D P MINOR**

ADDRESS: _____ ***Apt./ Unit/ Lot #*** _____

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

PRIMARY PHONE: _____ **HOME CELL ALTERNATE #** _____

DOES YOUR PRIMARY NUMBER ACCEPT TEXT MESSAGES YES OR NO (CIRCLE ONE)

PREFERRED METHOD OF COMMUNICATION: TEXT MESSAGE OR EMAIL

EMAIL: _____

EMPLOYER: _____

Please Check: ❒ EMPLOYED ❒ UNEMPLOYED ❒ DISABLED ❒ RETIRED ❒ MINOR

EMERGENCY CONTACT: _____ PHONE: _____

PARENT's NAME (*IF PATIENT IS A MINOR*): _____ PARENT's BD: _____

#

FAMILY DOCTOR (must have) _____ PHONE: _____

HOW DID YOU HEAR ABOUT OUR OFFICE? ❒ Doctor Referral ❒ Family/Friend

❒ Social Media ❒ Internet ❒ Google

>>>>>>>>>>>>>>>> **INSURANCE INFORMATION** <<<<<<<<<<<<<<<<

1st Insurance: _____ OFFICE VISIT CO-PAY $ _____

2nd Insurance: _____

INSURANCE SUBSCRIBER INFORMATION

SUBSCRIBER'S NAME: (if person is other than the patient) _____

Birth Date: _____ Subscriber's SSN: _____

Employer: _____ *Patient's Relationship* to Insured: _____

(OVER)

WHAT IS YOUR FOOT/ANKLE PROBLEM: ______________________________

WHEN DID THIS PROBLEM START: ______________________________

WAS THERE ANY PREVIOUS FOOT/ANKLE TREATMENT: ☐ YES ☐ NO

*#

CURRENT MEDICATIONS: (NAME AND DOSAGE) ______________________________

____

____

List medical ALLERGIES or REACTIONS: ______________________________

____

SURGERY WITHIN THE ***LAST 5 YEARS***: ______________________________

____

PLEASE CHECK ALL CONDITIONS THAT APPLY TO THE PATIENT

- ☐ **ANEMIA**
- ☐ **ARTHRITIS**
  - ☐ **Osteoarthritis**
  - ☐ **Rheumatoid**
- ☐ **ASTHMA**
- ☐ **BLEEDING DISORDER**
- ☐ **CANCER Type?** ______________
  Year Diagnosed ______________
  - ☐ **Chemotherapy**
  - ☐ **Radiation**
- ☐ **DIABETES TYPE 1 or 2**
  Results of Last AIC __________
- ☐ **DVT's or BLOOD CLOTS**
- ☐ **FIBROMYALGIA**
- ☐ **GLAUCOMA**
- ☐ **GOUT**
- ☐ **HEART TROUBLE**
- ☐ **HIGH BLOOD PRESSURE**
- ☐ **STROKE / TIA's**
- ☐ **HIGH CHOLESTEROL**
- ☐ **KIDNEY DISEASE**
- ☐ **LUPUS**
- ☐ **NEUROPATHY – PERIPHERAL**
- ☐ **PSORIASIS**
- ☐ **THYROID DISEASE**

DO YOU HAVE:

- ☐ **Aneurysm Clips**
- ☐ **Pacemaker**

Have you ever worked with metal?

☐ **Yes** ☐ **No**

Please enter the following for your medical records:

HEIGHT: ___________ **WEIGHT:** ___________ **SHOE SIZE:** ____________

ARE YOU ON A DIABETIC DIET? ☐ YES ☐ NO

DO YOU SMOKE? ☐ YES* ☐ NO .... ***IF SO, How Many PER DAY:** ________________

FORMER SMOKER? ☐ YES ☐ NO

DO YOU DRINK? ☐ YES ☐ NO ☐ OCCASIONALLY

ARE YOU USING ANY TYPE OF CBD OR MARIJUANA PRODUCTS? ☐ YES ☐ NO

COULD YOU POSSIBILY BE PREGNANT? ☐ YES ☐ NO

<u>HAVE YOU HAD / IS THERE A CHANCE YOU HAVE?</u>

TB: YES ____ NO _____ **HIV: YES ____ NO ____** **Hepatitis: YES ____ NO ____**

#

RACE...required for your medical records... Check ALL that apply

☐ WHITE ☐ HAWAIIAN /PACIFIC ☐ BLACK ☐ ASIAN

☐ AMERICAN INDIAN/ALASKAN ☐ NOT SPECIFIED

#*#*#*#*#*#*#*#*#*#*#*#*#*#*#*#*#*#*#*#

ETHNICITY ....required for your medical records... CIRCLE ALL THAT APPLY

☐ White / NOT Hispanic or Latino ☐ Hispanic or Latino ☐ Not Specified

I AUTHORIZE PAYMENT OF MEDICAL BENEFITS AND THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS THE CLAIM TO *<u>Shoreline Foot & Ankle Associates, P.C.</u>* I UNDERSTAND I WILL BE RESPONSIBLE FOR ANY OUTSTANDING BALANCE NOT COVERED BY MY INSURANCE.

SIGNATURE: ______________________________________ *DATE:* ______________