SHORELINE FOOT & ANKLE ASSOCIATES, PC

PATIENT HISTORY

PATIENT: ______________________ DATE: ______________

BIRTH DATE: ______________ AGE: ______ Patient's SSN #: ______________

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

ADDRESS: ______________________ Apt./ Unit/ Lot # __________

CITY: ______________________ STATE ________ ZIP: ______________

PRIMARY PHONE: ______________ **ALT PHONE:** ______________

EMAIL: ______________________

Spouses Name ______________ Spouses Birth Date ______________

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

EMPLOYER: ______________ WK PHONE: ______________

EMERGENCY CONTACT: ______________ PHONE: ______________

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FAMILY DOCTOR: ______________ PHONE: ______________

REFERRED BY: ______________________

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1ST Insurance: ______________ **OFFICE VISIT CO-PAY** $ ______________

2ND Insurance: ______________________

IF YOU, THE PATIENT, ARE THE SUBSCRIBER (ONE WHO CARRIES THE INSURANCE) **.....**

YOU DO NOT NEED TO FILL OUT SUBSCRIBER INFORMATION BELOW:

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

Birth Date: ______________ Subscriber's SSN: ______________

Employer: ______________ Relationship To Patient: ______________

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WOULD YOU CONSIDER YOUR CURRENT HEALTH TO BE :

☞☞☞ *CIRCLE ONE*: GOOD FAIR POOR

HEIGHT: ______ **WEIGHT:** ________ **SHOE SIZE:** ________ DO YOU BRUISE EASILY? ______

ARE YOU ON A SPECIAL DIET? **YES**____**NO**______ /// ARE YOU PREGNANT? **YES**_____**NO**_____

DO YOU SMOKE? **YES**____ **NO**____ /// **FORMER SMOKER?** YES____ NO____

DO YOU DRINK? **YES**_____ **NO** _____ **OCCAS** ____

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WHAT IS YOUR FOOT/ANKLE PROBLEM: ______________________

WHEN DID THIS PROBLEM START: ______________________

WAS THERE ANY PREVIOUS FOOT/ANKLE TREATMENT: YES ____________ NO ___________

IF YES, DESCRIBE: ______________________

ANY SPECIFIC INJURY TO YOUR FOOT/ANKLE: YES _____________ NO __________________

IF YES DESCRIBE: ______________________

CURRENT MEDICATIONS: (or bring list and we'll copy it here)________________________________

____

____

MEDICAL ALLERGIES: ____

____

SURGERY WITHIN THE LAST 5 YEARS: ____

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PLEASE CHECK ANY OF THE FOLLOWING CONDITIONS YOU HAVE

❒ ANEMIA	❒ DIABETES	❒ KIDNEY DISEASE
❒ ARTHRITIS	❒ EPILEPSY	❒ POLIO
❒ ASTHMA	❒ GLAUCOMA	❒ STROKE
❒ BLEEDING DISORDER	❒ GOUT	❒ TUMORS
❒ HIGH CHOLESTEROL	❒ HEART TROUBLE	❒ ULCERS
❒ CANCER-----If yes, what type?__________________________	❒ HIGH BLOOD PRESSURE	❒ VARICOSE VEINS… …. DVT's? **or** Blood Clots?

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DO YOU HAVE OR IS THERE A CHANCE YOU HAVE?

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

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RACE: (check all that apply…required for your medical records)

- o WHITE
- o BLACK
- o AMER INDIAN/ALASKAN
- o HAWAIIAN OR PACIFIC
- o ASIAN
- o NOT SPECIFIED

ETHNICITY: (check all that apply….required for your medical records)

- o White / NOT Hispanic or Latino
- o Hispanic or Latino
- o Not Specified

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

SIGNATURE: *DATE:*

PATIENT CONSENT (HIPAA) FORM

Date: _____

I understand that under the *Health Insurance Portability & Accountability Act of 1996 (HIPAA)*, I have 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 understand that I may request in writing how you may restrict my private information. 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 content that you have taken action relying on this consent.

Print Patient Name:_____

Signature:_____

If you're a guardian of ,OR patient is a minor – Your Relationship to Patient _____

Please list the names and relationship of those whom you'd <u>give us permission to leave a phone message</u> with OR <u>someone who might call on your behalf</u> regarding your patient account information and/ or podiatry (foot) care.

1.)_____Phone # _____ Relationship _____

2.)_____Phone # _____ Relationship _____

3.)_____Phone # _____ Relationship _____