PATIENT NAME: _______________ _______________ ___ **DATE OF BIRTH:** ___/___/___ AGE: ___ SEX: M F

LAST FIRST MI

HOME ADDRESS: __________________________________ CITY/STATE: _____________________ ZIP: ___________

MAY WE LEAVE A MESSAGE?

HOME PHONE #: (____) ____-_______ YES NO

WORK PHONE #: (____) ____-_______ YES NO

CELL PHONE #: (____) ____-_______ YES NO

E-MAIL: _________________________________ YES NO

PRIMARY LANGUAGE: _______________________

RACE:______________________________________ ETHNICITY:________________________________

DO YOU HAVE A LEGAL GUARDIAN OR HEALTHCARE POWER OF ATTORNEY? YES NO

IF YES, NAME: _________________________ RELATIONSHIP: ___________ PHONE #: (____) ____-______

EMERGENCY CONTACT: _________________________ RELATIONSHIP: ___________ PHONE #: (____) ____-______

PRIMARY CARE DOCTOR: ______________________________________ PHONE: ______________________________

PHARMACY: _________________________ LOCATION: _______________________ PHONE #: (____) ____-______

IS THERE A FAMILY MEMBER OR OTHER PERSON YOU WOULD LIKE FOR US TO SHARE YOUR MEDICAL INFORMATION?

_____ YES NAME(S) ____

_____ NO

WHO IS RESPONSIBLE FOR PAYMENT? ___________________________ RELATIONSHIP TO PATIENT? ______________

ADDRESS: _____________________ CITY/STATE: _______________ ZIP: ________ PHONE #: (____) ____-_____

WHO REFERRED YOU TO US?____

INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY NAME: ____

ADDRESS: _____________________ CITY/STATE: _______________ ZIP: ________ PHONE #: (____) ____-_____

INSURED NAME: _______________________ DATE OF BIRTH ____________ EMPLOYER ________________________

CONTRACT # ________________ GROUP # _________________

SECONDARY INSURANCE COMPANY NAME: ____

ADDRESS: _____________________ CITY/STATE: _______________ ZIP: ________ PHONE #: (____) ____-_____

INSURED NAME: _______________________ DATE OF BIRTH ____________ EMPLOYER ________________________

CONTRACT # ________________ GROUP # _________________

PATIENT NAME: ________________________________

DATE OF BIRTH: ____/____/_____

PLEASE LIST **ALL MEDICATIONS** YOU ARE CURRENTLY TAKING (INCLUDE PRESCRIPTIONS, OVER-THE-COUNTER MEDS AND HERBAL SUPPLEMENTS):

NAME DOSE HOW OFTEN DO YOU TAKE?

____

____

____

____

PLEASE LIST ALL PRIOR SURGERIES:

TYPE OF **SURGERY** DATE TYPE OF **SURGERY** DATE

____________________________________ ____________________________________

____________________________________ ____________________________________

PLEASE LIST ALL PRIOR HOSPITALIZATIONS (OTHER THAN FOR SURGERY):

REASON FOR HOSPITALIZATION DATE REASON FOR HOSPITALIZATION DATE

____________________________________ ____________________________________

____________________________________ ____________________________________

HEIGHT ________ **WEIGHT** _________ **SHOES SIZE** ________

SOCIAL HISTORY

MARITAL STATUS: ☐ SINGLE ☐ MARRIED ☐ PARTNERED ☐ SEPARATED ☐ DIVORCED ☐ WIDOWED

USE OF **ALCOHOL**: ☐ NEVER ☐ NO LONGER USE ☐ HISTORY OF ALCOHOL ABUSE
☐ CURRENT USE - TYPE ________________ ☐ RARE ☐ OCCASIONAL ☐ MODERATE ☐ DAILY

USE OF **TOBACCO**: ☐ NEVER ☐ QUIT – HOW LONG AGO? ________ ☐ SMOKE ____ PACKS/DAY FOR ____ YEARS

USE OF RECREATIONAL DRUGS: ☐ NEVER ☐ QUIT – HOW LONG AGO? ________ TYPE _____________________

☐ CURRENT USE - TYPE _____________ ☐ RARE ☐ OCCASIONAL ☐ MODERATE ☐ DAILY

EMPLOYER: ___________________________________ OCCUPATION: ____________________________________

HOW MUCH ARE YOU ON YOUR FEET AT WORK? ☐ 10% ☐ 25% ☐ 50% ☐ 75% ☐ 100%

DO OTHERS DEPEND UPON YOU FOR THEIR CARE? ☐ CHILDREN–AGE(S) ______ ☐ PET(S)–WHAT KIND? _______
☐ ELDERLY OR DISABLED FAMILY MEMBER ☐ OTHER ____

EXERCISE: ☐ NEVER ☐ RARE ☐ OCCASIONAL ☐ WEEKLY ☐ SEVERAL TIMES A WEEK ☐ DAILY

TYPES OF EXERCISE: ____

FAMILY HISTORY

DO YOU HAVE A FAMILY HISTORY OF: ☐ DIABETES: TYPE 1 OR TYPE 2 ☐ CANCER ☐ HEART DISEASE
☐ HIGH BLOOD PRESSURE ☐ STROKE ☐ CORONARY ARTERY DISEASE ☐ THYROID DISEASE
☐ RHEUMATOID ARTHRITIS
☐ OTHER ____

PATIENT NAME: _______________________________

DATE OF BIRTH: ____/____/_____

YOUR MEDICAL HISTORY

ALLERGIES: ☐ MEDICATIONS ____
☐ ANESTHESIA __________________________ ☐ FOODS ____________________________
☐ TAPE ☐ LATEX ☐ SHELLFISH ☐ IODINE ☐ OTHER ______________________________
☐ NONE KNOWN

HAVE YOU EVER HAD ANY OF THE FOLLOWING?

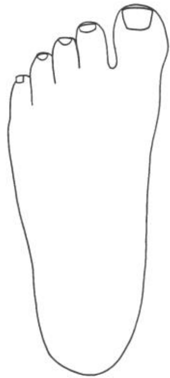
ACID REFLUX	Y	N	FIBROMYALGIA	Y	N	NEUROPATHY	Y	N
ANEMIA	Y	N	GOUT	Y	N	OPEN SORES	Y	N
ARTHRITIS	Y	N	HEART ATTACK	Y	N	PNEUMONIA	Y	N
ASTHMA	Y	N	HEART DISEASE/FAILURE	Y	N	POLIO	Y	N
BACK TROUBLE	Y	N	HEPATITIS	Y	N	RHEUMATIC FEVER	Y	N
BLADDER INFECTIONS	Y	N	HIV+/AIDS	Y	N	SICKLE CELL DISEASE	Y	N
ABNORMAL BLEEDING	Y	N	HIGH BLOOD PRESSURE	Y	N	SKIN DISORDER	Y	N
BLOOD CLOTS	Y	N	KIDNEY DISEASE	Y	N	SLEEP APNEA	Y	N
BLOOD TRANSFUSION	Y	N	LIVER DISEASE	Y	N	STOMACH ULCERS	Y	N
BRONCHITIS/EMPHYSEMA	Y	N	LOW BLOOD PRESSURE	Y	N	STROKE	Y	N
CANCER	Y	N	MIGRAINE HEADACHES	Y	N	THYROID DISEASE	Y	N
DIABETES: TYPE 1 OR TYPE 2 (CIRCLE)	Y	N	MITRAL VALVE PROLAPSE	Y	N	TUBERCULOSIS	Y	N
OTHER CONDITIONS:								

CURRENT PROBLEM

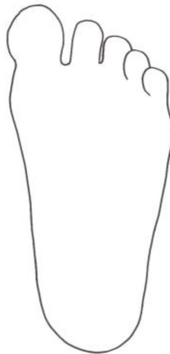
WHAT SPECIFIC PROBLEM BRINGS YOU TO OUR OFFICE TODAY? ______________________________

WHERE IS THE PAIN/PROBLEM LOCATED? PLEASE MARK ON THE PICTURES BELOW.

LEFT FOOT



TOP OF FOOT



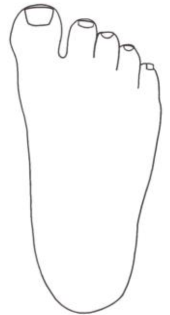
BOTTOM OF FOOT

INSIDE OF FOOT

OUTSIDE OF FOOT

RIGHT FOOT

BOTTOM OF FOOT



TOP OF FOOT

OUTSIDE OF FOOT

INSIDE OF FOOT

PATIENT NAME: ________________________________
DATE OF BIRTH: ____/____/_____

HOW LONG AGO DID THIS PROBLEM FIRST START? _________ DAYS / WEEKS / MONTHS / YEARS

DID YOUR PAIN OR PROBLEM: ☐ BEGIN ALL OF A SUDDEN ☐ GRADUALLY DEVELOP OVER TIME

HOW WOULD YOU DESCRIBE YOUR PAIN? ☐ NO PAIN ☐ SHARP ☐ DULL ☐ ACHING ☐ BURNING
☐ RADIATING ☐ ITCHING ☐ STABBING ☐ OTHER ______________________________

HOW WOULD YOU RATE YOUR PAIN ON A SCALE FROM 0 TO 10? (PLEASE CIRCLE)
(NO PAIN) 0 1 2 3 4 5 6 7 8 9 10 *(WORST PAIN POSSIBLE)*

SINCE THE TIME YOUR PAIN OR PROBLEM BEGAN, HAS IT: ☐ STAYED THE SAME ☐ BECOME WORSE ☐ IMPROVED

WHAT MAKES YOUR PAIN OR PROBLEM FEEL WORSE? ☐ WALKING ☐ STANDING ☐ DAILY ACTIVITIES
☐ RESTING ☐ DRESS SHOES ☐ HIGH HEELS ☐ FLAT SHOES ☐ ANY CLOSED TOE SHOE
☐ RUNNING ☐ OTHER ______________________________

WHAT MAKES YOUR PAIN OR PROBLEM FEEL BETTER? ______________________________

WHAT TREATMENTS HAVE YOU HAD FOR THIS PROBLEM? ______________________________

HOW HAS THIS PROBLEM AFFECTED YOUR LIFESTYLE OR ABILITY TO WORK? ______________________________

WAS THIS PROBLEM CAUSED BY AN INJURY? ☐ YES (DESCRIBE) ______________________________ ☐ NO

IF YES, WAS IT A WORK-RELATED INJURY? ☐ YES ☐ NO

TO THE BEST OF MY KNOWLEDGE, I HAVE ANSWERED THE QUESTIONS ON THIS FORM ACCURATELY. I UNDERSTAND THAT PROVIDING INCORRECT INFORMATION CAN BE DANGEROUS TO MY HEALTH. I UNDERSTAND THAT IT IS MY RESPONSIBILITY TO INFORM THE DOCTOR AND OFFICE STAFF OF ANY CHANGES IN MY MEDICAL STATUS.

____
PRINT NAME OF PATIENT, PARENT OR GUARDIAN

____
IF OTHER THAN PATIENT, RELATIONSHIP TO PATIENT

____
SIGNATURE

____
DATE

E-PRESCRIBING CONSENT

PATIENT NAME: _______________________________
DATE OF BIRTH: ____/____/_____

E-PRESCRIBING CONSENT

E-PRESCRIBING IS DEFINED BY A PHYSICIANS ABILITY TO ELECTRONICALLY SEND AN ACCURATE, ERROR FREE, AND UNDERSTANDABLE PRESCRIPTION DIRECTLY TO YOUR PHARMACY. CONGRESS HAS DETERMINED THAT THE ABILITY TO ELECTRONICALLY SEND PRESCRIPTIONS IS AN IMPORTANT ELEMENT IN IMPROVING THE QUALITY OF PATIENT CARE. E-PRESCRIBING GREATLY REDUCES MEDICATION ERRORS AND ENHANCES PATIENT SAFETY. THE MEDICARE MODERNIZATION ACT 2003, LISTED STANDARDS THAT HAVE TO BE INCLUDED IN AN E-PRESCRIBING PROGRAM. THESE INCLUDE: (1) FORMULARY AND BENEFIT TRANSACTIONS, WHICH GIVES THE PRESCRIBER INFORMATION ABOUT WHICH DRUGS ARE COVERED BY A DRUG BENEFIT PLAN; (2) MEDICATION HISTORY TRANSACTIONS, WHICH PROVIDES THE PHYSICIAN WITH INFORMATION ABOUT MEDICATIONS THE PATIENT IS ALREADY TAKING TO MINIMIZE ADVERSE DRUG EVENTS.
I AUTHORIZE ADVANCED ANKLE AND FOOT CENTER, TO VIEW MY EXTERNAL PRESCRIPTION HISTORY VIA ELECTRONIC E-PRESCRIBING SERVICES. I UNDERSTAND THAT PRESCRIPTION HISTORY FROM MULTIPLE, OTHER UNAFFILIATED, PROVIDERS, INSURANCE COMPANIES, PHARMACIES AND PHARMACY BENEFIT MANAGERS MAY BE VIEWABLE BY THE PROVIDERS AND STAFF OF ADVANCED ANKLE AND FOOT CENTER, AND IT MAY INCLUDE PRESCRIPTIONS BACK IN TIME FOR SEVERAL YEARS AND MAY INCLUDE PRESCRIPTIONS TO TREAT HIV, SUBSTANCE ABUSE AND PSYCHIATRIC CONDITIONS. IF APPLICABLE, I UNDERSTAND THAT MY PRESCRIPTION HISTORY WILL BECOME PART OF MY RECORD AT THIS PRACTICE. UNDERSTANDING ALL OF THE ABOVE, I HERBY PROVIDE INFORMED CONSENT TO ADVANCED ANKLE AND FOOT CENTER, TO ENROLL ME IN THE E-PRESCRIBE PROGRAM. THIS CONSENT WILL REMAIN ENFORCED UNTIL REVOKED OR CHANGED.

______________________________	______________________________
PATIENT SIGNATURE	PARENT/LEGAL GUARDIAN SIGNATURE

I CERTIFY, TO THE BEST OF MY KNOWLEDGE, I HAVE ANSWERED THE QUESTIONS ON THIS FORM ACCURATELY. I UNDERSTAND THAT PROVIDING INCORRECT INFORMATION CAN BE DANGEROUS TO MY HEALTH. I UNDERSTAND THAT IT IS MY RESPONSIBILITY TO INFORM THE DOCTOR AND OFFICE STAFF OF ANY CHANGES IN MY MEDICAL STATUS.

I GIVE PERMISSION TO THE DOCTORS AT ADVANCED ANKLE AND FOOT CENTER, LLC, TO ADMINISTER AND PERFORM ANY DIAGNOSTIC, THERAPEUTIC AND/OR OPERATIVE PROCEDURES AS MAY BE DEEMED MEDICALLY NECESSARY IN DIAGNOSIS AND/OR TREATMENT OF MY CONDITION.

PATIENT/MINORS UNDER THE AGE OF 18, WILL NOT BE TREATED WITHOUT A PARENT OR LEGAL GUARDIAN PRESENT. IF ANOTHER FAMILY MEMBER, CARE TAKER OR FRIEND, OVER THE AGE OF 18 WILL BE PRESENT; WRITTEN CONSENT FROM THE PARENT/LEGAL GUARDIAN STATING AS SUCH MUST BE PRESENTED AT THE TIME OF THE APPOINTMENT. THANK YOU.

______________________________	______________________________
PRINT NAME OF PATIENT	PRINT PARENT/LEGAL GUARDIAN
______________________________	______________________________
PATIENT SIGNATURE	SIGNATURE PARENT/LEGAL GUARDIAN
______________________________	
DATE	