PATIENT INFORMATION

Name: ______________________________

Date of Birth: ____________ Age: ________ Gender: ________

Height: ____________ Weight: ________ Shoe Size: ________

Street Address: ______________________________

Mailing Address (if different): ______________________________

Home Phone: ( ) ____________ Cell Phone: ( ) ____________

Email: ______________________________ **We use email to confirm future appts**

Occupation: ______________________________

Social Security Number: ______________________________

Pharmacy Name: ______________________________

Pharmacy Location: ______________________________

Race: (circle one) American Indian Alaskan Native Asian Native Hawaiian

Black/African American White Hispanic Other: ____________

Ethnicity: Hispanic ________ Non-Hispanic ________

Marital Status: Single _____ Married _____ Divorced/Separated _____ Widowed _____

Spouse's Name (if applicable) ______________________________

INSURANCE INFORMATION (Fill out if insurance cards were **NOT** provided at the time of your visit)

Primary Insurance Co: ____________ Insured's Name: ____________

Insured's SS#: ____________ Insured's Group #: ____________

Secondary Insurance Co: ____________ Insured's Name: ____________

Insured's SS#: ____________ Insured's Groups #: ____________

BACKGROUND INFORMATION

Family Doctor/PCP: ______________________________

Last visit date (approximately) ______________________________

How did you hear about our office? ______________________________

Please describe your present foot/ankle problem(s): ______________________________

Any previous treatment(s): ______________________________

PATIENT NAME: ________________________

MEDICAL HISTORY

Check any of the following medical conditions that you now have, or have had in the past:

	AIDS/HIV		Blood Clot		Problem with Walking/Gait
	Anemia		Diabetes		Rheumatoid Arthritis
	Problems with Anesthesia		How long? Insulin: Y or N		Sexually Transmitted Disease
	Arthritis		Gout		Stomach Ulcers
	Cancer		Heart Attack/MI		Stroke
	Type:		Hepatitis		Swelling of Feet/Ankles
	Chronic Kidney Disease		High Blood Pressure		Thyroid Problems
	Circulation Problems		High Cholesterol		Tuberculosis
	Congestive Heart Failure		Liver Disease		Varicose Veins
	COPD/Asthma/Emphysema		Muscular Disorder		Wound Healing Problems

Any other medical conditions/diagnosis: ____

ALLERGIES

Please check any medical/drug allergies you may have:

	NO KNOWN ALLERGIES		Sulfa
	Adhesives		Local Anesthetics
	Codeine		Penicillin
	Iodine		Other: (Please Specify)

MEDICATION AND DOSAGE **(If you brought a list, please attach)**

	Medication	Strength (mg)	# of pills per day
1.			
2.			
3.			
4.			
5.			

ORTHOPEDIC SURGERIES

Please check any surgeries you may have had in the past:

- ☐ Appendix
- ☐ CABG/Stents
- ☐ Gallbladder Surgery
- ☐ Hernia Repair
- ☐ Hip Repair/Replacement Right _____ Left _____
- ☐ Knee Replacement Right _____ Left _____
- ☐ Foot Surgery Right _____ Left _____

What kind of procedure(s): ______________________________

____

Any problem with general or local anesthesia? ☐ Yes ☐ No Describe: ______________________

PATIENT NAME: ___________________________

SOCIAL HISTORY

Do you drink Alcohol? ☐ Yes ☐ No

If yes, how often? ☐ Socially ☐ Occasionally (1-2/wk) ☐ Regularly (3-5+/week)

Do you smoke or use Tobacco products? ☐ Yes ☐ No ☐ Former Smoker

If yes, for how long? ________________________________

If former smoker, what year did you quit? ___________________________________

Packs smoked per day: ☐ < ½ ☐ ½ ☐ 1 ☐ 2 ☐ >2

FAMILY HISTORY

List any blood relatives with a history of:

- ☐ Blood clots/excessive bleeding Relationship: ____
- ☐ Adverse reaction to anesthesia Relationship: ____
- ☐ Cardiac disorders Relationship: ____
- ☐ Cancer Relationship: ____
- ☐ Diabetes Relationship: ____
- ☐ Auto-immune Disorders Relationship: ____

I hereby give Valley Foot & Ankle Specialists permission to examine and administer treatment, after consultation, and perform such procedures as may be deemed necessary in the diagnosis and/or treatment of my foot or ankle condition. I also assign to Valley Foot & Ankle Specialists all payment for medical services rendered to myself or my dependent. I understand that I am responsible for any amount not covered by my insurance carrier. I also authorize release of medical information necessary to process any health insurance claims or for referral to other specialties. A copy of my signature on file will be considered as valid as the original.

____ ________________________

Signature of Patient/Parent/Guardian Date

CONSENT OF CARE:

I hereby give my consent for treatment to Valley Foot & Ankle Specialists (Dr. Rivera and Dr. Payne) for services. These may include, but are not limited to: examination, x-rays, injections, photos, and treatments which my physician and I agree are necessary.

AUTHORIZATION TO OBTAIN/RELEASE MEDICAL RECORDS:

I authorize Valley Foot & Ankle Specialists, or any person designated by them to obtain/release copies of my medical records to any physician or institution for the purpose of evaluation and/or comparison with examination and testing being performed on me/my dependent.

AUTHORIZATION TO PAY BENEFITS TO PHYSICIANS:

I hereby authorize payment to Valley Foot & Ankle Specialists for services rendered to me or my dependent. I also authorize this office to release any information necessary to expedite insurance claims. To the extent permitted by law, I authorize holder to release information to CMS and applicable government agencies regarding determining benefits for service. I understand that I am responsible for any balance not covered by insurance and/or collection costs and legal fees incurred in any attempt to collect said balance. I assign all medical and surgical benefits to Valley Foot & Ankle Specialists.

PATIENT HIPPA ACKNOWLEDGEMENT AND DESIGNATION:

I have been given an opportunity to read the Health Information Portability & Accountability Act of 19996 (HIPPA)

I hereby authorize Valley Foot & Ankle Specialists to leave messages regarding pending appointments and/or lab or diagnostic results at my residence or via voice mail. You may notify me through (check all that apply)

☐ Cell Phone ☐ Home Phone ☐ Spouse ☐ Family/Friend

____
Please specify name of designated person(s)

Please acknowledge that you have read and agree to all the above statements by signing below

Patient's Name (please print): ______________________________

Signature of Patient/Parent/Guardian: ______________________ Date: ____________