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PATIENT INFORMATION FORM

Please Print

PATIENT NAME: _____DATE OF BIRTH: _____/_____/_____ SEX: ☐M☐F
FIRST MI LAST

ADDRESS: _____ CITY: _____STATE:_____ZIP CODE: _____

HOME PHONE: _____ CELL PHONE: _____WORK PHONE: _____

CAN WE LEAVE A MESSAGE? ☐ HOME PHONE ☐ CELL PHONE ☐ WORK PHONE

PREFERRED CONTACT #: ☐ HOME PHONE ☐ CELL PHONE ☐ WORK PHONE

SOCIAL SECURITY NUMBER: _____ ETHNICITY: _____

EMERGENCY CONTACT: _____RELATIONSHIP:_____ PHONE #_____

PRIMARY CARE PHYSICIAN: _____ PHONE: _____

PHARMACY: _____ PHARMACY LOCATION: _____PHONE # _____

IS THERE A FAMILY MEMBER OR OTHER PERSON YOU WOULD LIKE FOR US TO SHARE YOUR MEDICAL INFORMATION?
☐ YES ☐ NO
IF YES, LIST NAMES _____

WHO REFERRED YOU? ☐ FRIEND/FAMILY _____ ☐ DOCTOR_____ ☐ INTERNET
☐ OTHER_____

BILLING ADDRESS: (IF DIFFERENT FROM HOME ADDRESS)

ADDRESS: _____ CITY: _____STATE:_____ZIP CODE: _____

SPOUSE, PARENT OR GUARDIAN INFORMATION:

NAME: _____DATE OF BIRTH: _____/_____/_____ SEX:☐M☐F
FIRST LAST

ADDRESS: _____ CITY: _____STATE:_____ZIP CODE: _____

EMPLOYER NAME: _____ ADDRESS: _____PHONE: _____

☐ SPOUSE ☐ PARENT ☐ OTHER

HEALTHCARE POWER OF ATTORNEY OR LEGAL GUARDIAN: ☐ YES ☐ NO (COMPLETE IF APPLICABLE)
(PLEASE PROVIDE THE OFFICE WITH A COPY OF HEALTHCARE POA)

PATIENT NAME: _____DATE OF BIRTH: _____/_____/_____
FIRST M.I. LAST

INSURANCE INFORMATION:

PRIMARY INSURANCE NAME: _____MEMBER ID: _____

GROUP: _____ PRIMARY POLICY HOLDER: _____

RELATIONSHIP TO POLICY HOLDER: ☐ SELF ☐ SPOUSE ☐ PARENT ☐OTHER: _____

POLICY HOLDER DOB: _____/_____/_____ EFFECTIVE DATE: _____/_____/_____

SECONDARY INSURANCE NAME: _____MEMBER ID: _____

GROUP: _____ PRIMARY POLICY HOLDER: _____

RELATIONSHIP TO POLICY HOLDER: ☐ SELF ☐ SPOUSE ☐ PARENT ☐OTHER: _____

POLICY HOLDER DOB: _____/_____/_____ EFFECTIVE DATE: _____/_____/_____

HEALTH QUESTIONS:

BRIEFLY DESCRIBE YOUR REASON FOR YOUR VISIT: _____
_____

HOW LONG HAVE YOU HAD THIS PROBLEM? _____ DAYS / WEEKS / MONTHS / YEARS

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)

WHAT TREATMENT HAVE YOU HAD FOR THIS PROBLEM? _____
_____

SHOE SIZE: _____

IF CONDITION IS DUE TO AN ACCIDENT, PLEASE DESCRIBE THE NATURE OF THE ACCIDENT: _____
_____

(IF APPLICABLE PLEASE COMPLETE THIS SECTION)

DATE OF INJURY: _____/_____/_____ PLACE OF INJURY: _____

DID YOU HAVE XRAYS DONE FOR THIS CONDITION? ☐ YES ☐ NO DATE OF X-RAY: _____/_____/_____

WHERE WERE THE XRAYS TAKEN? _____ DID YOU MISS SCHOOL/ WORK? ☐ YES ☐ NO

DATE RETURNED TO WORK/SCHOOL: _____/_____/_____

PATIENT NAME: _____DATE OF BIRTH: _____/_____/_____
FIRST M.I. LAST

MEDICAL HISTORY:

PLEASE LIST ALL PRIOR SURGERIES. IF NONE, PLEASE CHECK NONE. ☐ NONE

TYPE OF SURGERY	DATE	TYPE OF SURGERY	DATE

PLEASE LIST ALL PRIOR HOSPITALIZATIONS (OTHER THAN FOR SURGERY). IF NONE, PLEASE CHECK NONE. ☐ NONE

REASON FOR HOSPITALIZATION	DATE	REASON FOR HOSPITALIZATION	DATE

PLEASE LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING (INCLUDE PRESCRIPTIONS, VITAMINS, SUPPLEMENTS, OVER THE COUNTER) IF NONE, PLEASE CHECK NONE. (IF MORE SPACE IS NEEDED. PLEASE ATTACH ADDITIONAL SHEET) ☐ NONE

MEDICATION NAME: DOSE: FREQUENCY:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

ALLERGIES:

☐ NO KNOWN DRUG ALLERGIES ☐ ANESTHESIA: _____ ☐ LATEX ☐ IODINE ☐ TAPE

☐ MEDICATIONS: _____

HAVE YOU HAD ANY OF THE FOLLOWING? (PLEASE CIRCLE Y OR N)

ACID REFLUX	Y	N	FIBROMYALGIA	Y	N	OPEN SORES	Y	N
ANEMIA	Y	N	GOUT	Y	N	PACE MAKER	Y	N
ARTHRITIS	Y	N	HEART ATTACK	Y	N	PAST STROKE	Y	N
ASTHMA	Y	N	HEART DISEASE/FAILURE	Y	N	PROLONGED BLEEDING FROM SURGEY	Y	N
ABNORMAL BLEEDING	Y	N	HEPATITIS	Y	N	SICKLE CELL DISEASE	Y	N
BLOOD CLOTS	Y	N	HIV + / AIDS	Y	N	SLEEP APNEA	Y	N
BACK TROUBLE	Y	N	KIDNEY DISEASE	Y	N	STOMACH ULCER	Y	N
BLOOD TRANSFUSION	Y	N	LIVER DISEASE	Y	N	STROKE	Y	N
CANCER WHAT TYPE:	Y	N	LOW BLOOD PRESSURE	Y	N	THYROID DISEASE	Y	N
DIABETES: TYPE 1 OR TYPE 2 (CIRCLE WHICH TYPE)	Y	N	LUNG DISEASE	Y	N	PERIPHERAL VASCULAR DISEASE	Y	N
DVT OR PULMONARY EMBOLISM	Y	N	MIGRAINE HEADACHES	Y	N	OTHER:		
DEFIBRILLATOR	Y	N	NEUROPATHY	Y	N			

PATIENT NAME: _____DATE OF BIRTH: _____/_____/_____
FIRST M.I. LAST

SOCIAL HISTORY:

MARITAL STATUS: ☐ SINGLE ☐ MARRIED ☐WIDOWED ☐DIVORCED ☐ SEPARATED ☐ PARTNER NAME: _____

USE OF ALCOHOL: ☐ NEVER ☐ NO LONGER USE ☐ HISTORY OF ALCOHOL ABUSE ☐ 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: _____

ARE YOU PREGNANT? ☐ YES ☐ NO

FAMILY HISTORY:

DO YOU HAVE A FAMILY HISTORY OF?
☐ DIABETES TYPE 1 OR TYPE 2 ☐CANCER ☐ HEART DISEASE ☐ HIGH BLOOD PRESSURE ☐ STROKE ☐ BLEEDING DISORDER
☐ BLOOD VESSEL DISEASE (CIRCULATION PROBLEMS) ☐ RHEUMATOID ARTHRITIS ☐ OTHER_____

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.

AUTHORIZATION FOR RELEASE OF INFORMATION: I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION TO INSURANCE CARRIERS (INCLUDING MEDICARE) CONCERNING MY TREATMENT NECESSARY TO PROCESS THIS CLAIM TO FOOT & ANKLE ASSOCIATES OF GREATER PITTSSBURGH, LLC. I UNDERSTAND THAT ANY FALSE CLAIMS, STATEMENTS, DOCUMENTS OR CONCEALMENT OF MATERIAL FACT, MAY BE PROSECUTED UNDER FEDERAL AND STATE LAWS.

AUTHORIZATION FOR ASSIGNMENT OF PAYMENTS: I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO FOOT & ANKLE ASSOCIATES OF GREATER PITTSBURGH, LLC FOR SERVICES RENDERED TO ME. I UNDERSTAND THAT I AM RESPONSIBLE FOR ALL CHARGES, INCLUDING CO-PAYS AND CHARGES NOT COVERED BY INSURANCE.

I UNDERSTAND THAT REFERRAL FOR HMO PARTICIPANTS ARE THE PARTICIPANT'S RESPONSIBILITY. IF NO AUTHORIZATION WAS APPROVED PRIOR TO SERVICE, I ACCEPT FINANCIAL RESPONSIBLITY FOR SERVICES RENDERED. THIS PAYMENT WILL BE DUE AT TIME OF SERVICE.

IF I HAVE A LIABILITY CLAIM FOR MY MEDICAL SERVICES, SUCH AS AUTO, WORKERS' COMPENSATION, ACCIDENT, ECT., I UNDERSTAND THAT I AM ULTIMATLEY LIABLE FOR SERVICES RENDERED TO ME AND I AGREE TO PAY DIRECTLY TO FOOT & ANKLE ASSOCIATES OF GREATER PITTSBURGH, LLC SHOULD MY CLAIM WITH THE INSURANCE CARRIER AND / OR POLICY HOLDER BE DENIED OR CHALLENGED.

CONSENT FOR TREATMENT: I AUTHORIZE TREATMENTS TO MYSELF, OR AS AN AUTHORIZED PERSON OF THE PATIENT, BY FOOT & ANKLE ASSOCIATES OF GREATER PITTSBURGH, LLC INCLUDING EMPLOYEES THEREIN.

CONSENT TO CONTACT BY CELL PHONE OR TEXT: I AUTHORIZE FOOT & ANKLE ASSOCIATES OF GREATER PITTSBURGH, LLC. OR ITS AGENTS TO CONTACT GUARANTOR AND / OR PATIENT BY CELL PHONE OR TEXT FOR PURPOSES NOTIFYING APPOINTMENTS, OUTSTANDING BILLS, TEST RESULTS, AND OTHER MEDICAL PRACTICE ACTIVITIES. I UNDERSTAND I CAN REVOKE THIS AT ANYTIME IN WRITING.

X_____ **X** _____
PRINT NAME OF PATIENT, PARENT OR GUARDIAN SIGNATURE

_____ _____
IF OTHAN THAN PATIENT, RELATIONSHIP TO PATIENT DATE