Today's Date: _____ Name: _____

Date of birth: _____ Sex: _____ Marital Status: _____Race: _____

SS #: _____ Preferred Language: _____ Email: _____

Local Address: _____

Home phone: _____Cell: _____ Permission to send text reminders or leave voicemail?
Yes ☐ No ☐

Secondary Address: _____

Emergency contact name: _____ Relation: _____Phone: _____

Primary care Physician: _____ Phone: _____Date of last visit: _____

Whom may we thank for the referral?_____

Pharmacy name/location: _____

MEDICAL HISTORY: Please check any illness you have ever had or presently have.

___ Diabetes ___ Rheumatic Fever ___ High Blood Pressure ___Stroke

___Shortness of Breath ___Venereal Disease ___ Tuberculosis ___ Fainting

___Asthma ___ Epilepsy ___Hepatitis ___Leukemia

___Cancer/Tumor ___Excessive Bleeding ___Anemia ___HIV/AIDS ___Other: _____

Reason for today's visit: _____

Date of Injury or length of symptoms: _____

On the scale of 1-10, 10 being the worst, how would you describe your pain level? _____ Is pain getting worse? _____

Have you ever had a similar problem or injury before? _____

What other treatments have you tried for this problem?

_____

Have you been treated by a Podiatrist or Orthopedist in the past? _____ Treatments rendered:

_____

Smoking Status: Never Former Current How many? _____ Do you drink? Y N How much? _____

Are you pregnant or think you may be pregnant? Y N **Social Status:** Student Employed Unemployed Retired Disabled

List any drug allergy and type of reaction:

_____

Please list **ALL** medications you are currently taking:

_____

_____

Height: _____Weight: _____ B/P_____ Shoe size _____

Family history:

_____

_____

Surgical history:

_____

_____

Review of systems

Please circle all that apply to you:

General: Fever, Chills, Night sweats, Weight Change, Appetite

Neck: Pain

Skin: Rashes, Growing Moles, Non-healing Lesions

Head: Headaches, Dizziness

Musculoskeletal: Bone Pain, Joint Pain, Joint Swelling, Muscle Aches, history of fracture

Eyes: Last Eye Exam_____, Change in Vision, Pain, Double Vision

Ears: Pain, Discharge, Decreased Hearing, Ringing

Cardiovascular: Chest Discomfort, Palpitations

Nose: Bleeding, Discharge, Sinus Pain

Mouth & Throat: Sores, Teeth, Bleeding gums

Psychiatric: Anxiety, Sadness, Moodiness, Irritability

Respiratory: Cough, Wheezing, Sputum, Hemoptysis, shortness of breath, chest Pain, Snoring

Gastrointestinal: Trouble Swallowing, Heartburn, Nausea, Vomiting, Pain, Constipation, Diarrhea

Neurology: Paralysis, Weakness of Extremities, Paresthesia, Transient Loss of Speech, or Vision, Memory Loss, Vertigo

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HIPAA Notice of Privacy Practices Acknowledgement

I have read and understand the HIPAA Notice of Privacy Practices. I am giving Elite Foot & Ankle Specialists permission to share my health information with the following individual:

Name: _____ Relationship: _____Phone#:_____

Please note: This authorization will remain effective until written notice is given to us by you, the patient.

Signature: _____ Date: _____

Financial Policy Acknowledgement/Signature on file

a) I authorize the use of this form on all insurance claim submissions on my behalf,

b) I authorize the release of all pertinent medical information to my insurance carrier to facilitate payment of medical claims submitted on my behalf;

c) I understand that, ultimately, I am responsible for fees associated with my treatment;

d) I authorize the release of payment whether payable to me, Elite Foot & Ankle Specialists or its associates directly to Elite Foot & Ankle Specialists;

e) I understand that I must provide all the necessary authorizations and/or referrals, should my plan require it, at the time of service; I further understand that should I not provide valid referral and/or authorization, I will be responsible for the cost of the visit.

f) I understand there will be a $25 no show fee if my appointment is not cancelled timely.

I HAVE READ AND FULLY UNDERSTAND THE FINANCIAL POLICY SET FORTH BY ELITE FOOT & ANKLE SPECIALISTS AND I AGREE TO THE TERMS OF THE FINANCIAL POLICY. I, ALSO, UNDERSTAND AND AGREE THAT THE TERMS OF THE FINANCIAL POLICY MAY BE AMENDED BY THE PRACTICE AT ANY TIME WITHOUT PRIOR NOTIFICATION TO THE PATIENT.

_____ _____

Signature of Patient/Guardian **Date**

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Consent/Attestation

I hereby consent and give my permission to the doctor (and the doctor's assistants or designated replacement) to administer and perform treatment of my concerns upon a thorough discussion with the doctor.

I also attest that all information provided is true to the best of my knowledge

_____ _____

Signature of Patient, Guardian, or Personal Representative **Date**

_____ _____

Please Print name of Patient, Guardian or Personal Representative **Relationship to Patient**