

PATIENT INFORMATION

NAME: _____ DATE: _____

MAILING ADDRESS: _____

PRIMARY PHONE: _____ ALTERNATE PHONE: _____

Is it okay to leave a message on your phone? Yes No EMAIL: _____

SEX: Male Female DATE OF BIRTH: _____ AGE: _____ SOCIAL SECURITY NO: _____

MARITAL STATUS (CIRCLE ONE) M S W D SEP SPOUSE'S NAME: _____

RACE: White Black Native American Asian Native Hawaiian Other Polynesian
 More than one race Unknown/Other/Prefer not to say

PREFERRED LANGUAGE: _____ ETHNICITY: Not Hispanic or Latino Hispanic or Latino

REFERRED BY: _____ PRIMARY DOCTOR: _____

PATIENT'S EMPLOYER: _____ OCCUPATION: _____

EMERGENCY CONTACT: _____ EMERGENCY PHONE #: _____

RELATIONSHIP TO PATIENT: _____

RESPONSIBLE PARTY (If applicable)

NAME: _____ RELATIONSHIP: _____

ADDRESS: _____ PHONE NUMBER: _____

INSURANCE INFORMATION (please have insurance cards and photo ID available)

COMPANY	INSURED NAME	RELATIONSHIP	INSURED ID#	INSURED BIRTHDATE	GROUP #
---------	--------------	--------------	-------------	-------------------	---------

1.

2.

COPAY AMOUNT: _____ INSURANCE DEDUCTIBLE: _____

HOW MUCH OF YOUR DEDUCTIBLE HAS BEEN MET? _____ SELF PAY (PLEASE MAKE PAYMENT ARRANGEMENTS PRIOR TO VISIT)

PATIENT NAME: _____

Medications you are currently taking:

Medication Name	Dosage	Times per day	Reasons for taking this medication

Do you have Diabetes? Yes No If yes, are you taking insulin? Yes No How many years? _____

Are you being treated for or have you been treated for any of the following? (check all that apply)

- Alcoholism
- Anemia
- Anxiety
- Arthritis
- Asthma
- Bi-polar
- Bronchitis
- Cancer/tumor
- Cholesterol
- COPD
- Dementia
- Depression
- Drug Abuse
- Emphysema
- Epilepsy
- Fibromyalgia
- GERD
- Gout
- Glaucoma
- Heart Attack
- Heart Murmur
- Hepatitis
- High Blood Pressure
- Hiatal Hernia
- Insomnia
- Lupus
- Migraines
- Osteoporosis
- Prostate
- Psoriasis
- Rheumatoid Arthritis
- Seizure
- Sleep Apnea
- Stomach Ulcers
- Stroke
- Thrombophlebitis
- Thyroid Disease
- Tuberculosis
- Urinary Incontinence

Are you currently pregnant? Yes _____ No _____ Due Date _____ Are you nursing? Yes _____ No _____

Please List all surgeries, diagnostic tests, or procedures that required anesthesia:

NAME: _____

Have you had any of the following? (Check all that apply)

GENERAL

- Recent weight loss
- Recent weight gain
- Chills
- Fever
- Night Sweats
- Excessive Tiredness
- Hospitalization within the last 5 years

If yes why? _____

HEAD, EYES, EARS, NOSE, THROAT

- Blurred Vision
- Hearing Problems
- Sinus Problems
- Glasses
- Contacts
- Sore throat
- Double vision
- Nose bleeds
- Dizziness

SKIN

- Eczema
- Skin Rash
- Athlete's foot
- Sweaty feet
- Change in Moles
- History of foot ulcers

RESPIRATORY

- Use of a C-PAP
- Shortness of breath
- Use of oxygen
- Cough
- Wheezing
- Difficulty breathing

CARDIOVASCULAR (heart)

- History of heart attack
- Irregular heart rate
- Chest pain
- Calf pain when exercise
- Legs give out if walking
- Poor Circulation
- Swelling (ankles/legs)

GASTROINTESTINAL

- Acid reflux
- Vomiting
- Blood in stool
- Diarrhea
- Constipation
- Nausea

MUSCULOSKELETAL

- Arthritis
- Early a.m. joint pain
- Low back pain
- Numbness in feet
- Prior foot/ankle fracture
- Joint swelling or pain

NEUROLOGICAL/PSYCHIATRIC

- Fainting
- Confusion
- Speech problems
- Neuropathy
- Poor balance

ENDOCRINE

- Excessive sweating
- Often feeling cold
- Frequent urination
- Often hungry
- Prostate problems

HEMATOLOGICAL

- Bleeding problems
- Blood clot in legs
- Blood clot in lungs
- Lump in groin
- Lump in arm pit
- Swollen glands

IMMUNOLOGICAL (immune system)

- Frequent infections
- Slow healing
- History of MRSA
- HIV/AIDS

Do you have any artificial joints? (Please list all) _____

Do you have a Heart Valve Implant? _____

FAMILY HISTORY

Is there a family (blood relative) history of:

- | | | | |
|--|---|--|---|
| <input type="checkbox"/> Anesthesia reactions | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Bleeding disorders | <input type="checkbox"/> Bunions |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Circulation problems | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Flatfeet |
| <input type="checkbox"/> Hammer toes | <input type="checkbox"/> Heart disease | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Malignant hypertension |
| <input type="checkbox"/> Neurological disorder | <input type="checkbox"/> Rheumatoid problems | <input type="checkbox"/> Stroke | |

NAME: _____

Mother	Living _____	Deceased _____	Cause of death _____
Father	Living _____	Deceased _____	Cause of death _____
Sister	Living _____	Deceased _____	Cause of death _____
Brother	Living _____	Deceased _____	Cause of death _____

SOCIAL HISTORY

Recreational activities: _____

Do you Smoke? Yes ___ No ___ If yes, how many packs per day? _____ How long have you been smoking? _____

Have you previously smoked? Yes ___ No ___ How many years did you smoke? _____

Do you drink alcohol (including beer/ wine)? Yes _____ No ___ If yes, how many times per week _____

Do you exercise regularly? Yes _____ No _____

At your place of employment, do you: (check all that apply)

Sit at job Stand at job Stand and walk at job Have a required shoe type

AUTHORIZATIONS

CONSENT FOR TREATMENT: I authorize necessary medical care to be rendered to the patient registered hereon.
(Initial) _____

FINANCIAL AGREEMENT AND RELEASE OF INFORMATION: I authorize the release of my personal health care information that might be required for processing my insurance claims by insurance companies through which I am covered, or any subsequent insurance companies from which I obtain coverage. (Initial) _____

I understand that my services will be billed to my insurance company(s) provided. I have given proof of my insurance coverage at the time services are rendered. If I do not have proof of insurance coverage at the time services are rendered, I understand that payment is due at the time of service. **I will promptly pay all amounts that have been determined my responsibility within 30 days of notification, or will discuss a payment plan with the billing department.** If I am *over* 18, I am ultimately responsible for any patient balance for services I received. If I am *under* the age of 18, my parent or legal guardian is responsible for my patient balance until my 18th birthday. (Initial) _____

I understand that it is my responsibility to coordinate my benefits with my insurance company(s). I am ultimately responsible for copays, deductibles, authorizations, eligibility, and etc. (initial) _____

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES: I acknowledge that I was referred to the Notice of Privacy Practices information page and that I have read (or had the opportunity to read if I so chose) and understand the Notice. (Initial) _____

Patient Signature _____ **Date:** _____

Signature of Parent/ Legal Guardian _____ **Date:** _____