Ashland / Mansfield Foot and Ankle Specialists

PATIENT NAME: _____

DOB: _____ SSN:_____ MARITAL STATUS:_____

ADDRESS:_____ CITY:_____

STATE:_____ ZIP CODE:_____

HOME PHONE:_____ MOBILE:_____

PATIENT EMPLOYER/SCHOOL: _____

ADDRESS:_____ PHONE:_____

OCCUPATION:_____ SHOE SIZE:_____

PRIMARY CARE PHYSICIAN:_____ PHONE NUMBER:_____

DIABETIC DOCTOR:_____PHONE NUMBER:_____

EYE DOCTOR_____ KIDNEY DOCTOR_____

PATIENT EMAIL:_____

SPOUSE/GUARDIAN: _____

SPOUSE DOB:_____ PHONE:_____

WHO CAN WE THANK FOR REFERRING YOU TO OUR PRACTICE?: _____

EMERGENCY CONTACT INFORMATION:

NAME: _____

PHONE:_____ RELATION TO PATIENT:_____

SOCIAL HISTORY (PLEASE CIRCLE ONE)

ALCOHOL USE PAST PRESENT NEVER HOW OFTEN? DAILY WEEKLY MONTHLY

TOBACCO/CIGARETTE PAST PRESENT NEVER HOW LONG?_____

RECREATIONAL DRUGS PAST PRESENT NEVER

ATHLETIC ACTIVITIES INVOLVED IN :_____

STAIRS IN HOME YES NO SUFFERED FALLS YES NO

AMBULATORY DEVICES (CANES, WALKERS, ETC) _____

ALLERGIES (PLEASE CIRCLE ONE)

ADHESIVE TAPE DEMEROL SEAFOOD ASPIRIN IODINE

CODEINE PENICILLIN LIDOCAINE BETADINE SULFA

LIST ANY ADDITIONAL ALLERGIES: _____

_____

ARE YOU PREGNANT? YES NO ARE YOU NURSING? YES NO

REASON FOR TODAYS VISIT :_____

IS THIS A WORKER'S COMPENSATION INJURY? YES NO
IF YES DATE OF INJURY:_____

MEDICAL HISTORY

PLEASE CIRCLE AND LIST ANY SURGERIES YOU HAVE HAD, INCLUDING YEAR PERFORMED

FOOT SURGERY EXPLAIN: _____
HEART SURGERY EXPLAIN: _____
AMPUTATION EXPLAIN: _____
APPENDECTOMY BREAST BIOPSY R/L BREAST MASTECTOMY R/L
CARPAL TUNNEL RELEASE R/L CATARACT R/L
CHOLECYSTECTOMY/GALLBLADDER REMOVAL HAND R/L EXPLAIN: _____
HERNIA REPAIR HIP R/L EXPLAIN: _____
HYSTERECTOMY KNEE R/L EXPLAIN: _____
SHOULDER R/L EXPLAIN: _____ TONSILLECTOMY
SPINAL PROCEDURE EXPALIN: _____
OTHER SURGERIES NOT LISTED:
_____
_____

PLEASE LIST CURRENT MEDICATION/VITAMINS:
_____
_____

PHARMACY OF CHOICE:
NAME:_____
ADDRESS:_____
PHONE:_____

FAMILY HISTORY:
PLEASE LIST ANY POTENTIALLY INHERITED FAMILY ILLNESSES:
_____
_____

PLEASE CIRCLE ANY CONDITIONS YOU HAVE OR HAVE HAD:

AIDS/HIV
Anemia
Angina/Chest Pain
Arthritis/Rheumatoid Arthritis
Artificial Heart Valves
Artificial Joints
Asthma
Back Problems
Bleeding Disorder/Hemophilia
Cancer-Explain_____
Chemical Dependency
Chronic Diarrhea
Circulation Problems
Diabetes Type I or Type II
Dialysis
Ear Problems
Epilepsy
Eye Problems- Cataracts Glaucoma
Fainting
Gout
Headache(s)
Heart Disease
Hepatitis A B C
Hypertension/High Blood Pressure
High Cholesterol
Kidney Problems
Leukemia
Liver Disease
Low Blood Pressure
Neuropathy
Phlebitis/Blood Clots/
Thrombus/DVT
Psychiatric Care
Pulmonary Embolism
Radiation Treatments-
Explain_____
Respiratory Disease /COPD
Rheumatic Fever
Sickle Cell Anemia
STD/Venereal Disease- Explain
_____
Stroke
Swelling of Ankles and Feet
Thyroid Issues
Tuberculosis
Ulcers- Digestive Skin
Varicose Veins
Weakness or Paralysis of Extremities
Weight Loss, Unspecified

MEDICAL CONDITIONS NOT LISTED: _____

ACKNOWLEDGEMENT OF RECEIPT
OF
NOTICE OF PRIVACY PRACTICES

Ashland/Mansfield Foot and Ankle Specialists

I acknowledge that I was offered a copy of the Notice of Privacy Practices and that I have read, or have had the opportunity to read if I so chose, and understand the Notice.
If you would like to view the Notice of Privacy of Practices, please ask the receptionist upon your arrival.

_____

Patient Name (please print)

_____

Parent or Authorized Representative

_____ _____

Signature Date

Please list any family members or acquaintances

You allow your medical information to be released to.

1._____

2._____

3._____

4._____

We participate in one or more Health Information Exchanges. Your healthcare providers can use this electronic network to securely provide access to your health records for a better picture of your health needs. We and other healthcare providers, may allow access to your healthcare information through the Health Information Exchange for treatment, payment or other healthcare operations. This is a voluntary agreement. You may opt-out at any time by notifying Cheri G., Office Manager of Ashland/Mansfield Foot and Ankle Specialists.

_____ _____

Signature Date

TREATMENT OF CONSENT

I hereby consent and give my permission to the doctor (and the doctor's assistants or designated replacement) to administer and perform, with further consent, such procedures upon me as the doctor deems necessary.

_____ _____

Patient or Authorized Signature Date

INSURANCE INFORMATION

Primary Insurance: _____ Subscriber SSN: _____

Secondary Insurance: _____ Subscriber SSN: _____

I, the undersigned, am aware that I am responsible for the payment of any co-pays and/or deductibles that may apply under my medical insurance contract. It is my responsibility to check with my insurance company to be sure that the physician is in my insurance network. I assume personal responsibility for any amount that insurance does not pay and deems payable by myself.

I also agree to pay all fees if I have no insurance coverage. It is my responsibility to have a referral at the time of service if needed. If I do not have a referral, I will pay all fees.

I am responsible for attending all appointments made at this doctor's office. I am responsible for informing the office if I am unable to make my appointment. I understand that I am only allowed to have 3 failed appointments within a year time span before being dismissed by the practice.

I, the undersigned, have received the Practice's Notice of Privacy Practices and understand that my protected health information may be used by the Practice as described in the notice.
I authorize the release of any medical information necessary to process my claims, and payment of government benefits to the above mentioned office.

_____ _____

Patient or Authorized Signature Date