PATIENT DEMOGRAPHICS

First Name ___________________________ **M.I.** _____ **Last Name** ____ **DOB** ____________

Street Address_________________________________ **City** __________________________ **State** __________ **Zip code** ________________

Home Phone (_______) ___________________ **Work Phone** (_______) __________________ **Cell Phone** (_______) ____________________

E-Mail Address ____

Gender ☐ F ☐ M **Marital Status** ☐ Married ☐ Divorced ☐ Separated ☐ Single ☐ Widowed **1st Lang.** ☐ Engl. ☐ Other ____________

Race: (Choose all that apply)
☐ White
☐ Native Hawaiian or other Pacific Islander
☐ Asian
☐ Black or African American
☐American Indian or Alaska Native
☐ Other

Ethnicity: (Also choose one that applies
☐ Hispanic
☐ Not Hispanic

Pharmacy of Choice ____________________________________ **Pharm. Phone** ____
Pharmacy Full Address ____
Primary Care Physician ____

Are you diabetic? ☐Yes ☐ No **If yes, name of physician managing diabetes** _____________________________ **Date last seen** ___________

Employed ☐ PT ☐ FT ☐ Retired ☐ None **Employer** ____
How did you hear about our practice? ____

☐ Internet (Source_____________________________________) ☐ Friend/Family Member/Patient (Name: _______________________________)

Emergency Contact ____________________________________ **Relationship to Patient** ___________________________
Cell Phone Number (______) ____________________ **Alternate Phone Number** (______) _____________________

Pharmacy of Choice ____________________________________ **Pharm. Phone** ____
Pharmacy Full Address ____
Primary Care Physician ____

Are you diabetic? ☐Yes ☐ No **If yes, name of physician managing diabetes** _____________________________ **Date last seen** ___________

Employed ☐ PT ☐ FT ☐ Retired ☐ None **Employer** ____
How did you hear about our practice? ____
☐ If referred by someone (ex. doctor, friend, family member or patient) please provide their name: ____

Emergency Contact ____________________________________ **Relationship to Patient** ___________________________
Cell Phone Number (______) ____________________ **Alternate Phone Number** (______) _____________________

INSURANCE INFORMATION

Patient Name: ____ Date of Birth: _________________ Today's Date: _________________

PRIMARY
Insurance Company: ____________________________________ **Insurance ID Number:** ___________________________________

Group Number: ____ **Primary Subscriber Name:** _______________________________

Primary Subscriber Birth Date: ____________________________ **Relationship to Patient:** _________________________________

SECONDARY
Insurance Company: ____________________________________ **Insurance ID Number:** ___________________________________

Group Number: ____ **Primary Subscriber Name:** _______________________________

Primary Subscriber Birth Date: ____________________________ **Relationship to Patient:** _________________________________

Financially Responsible Person if not Patient: First Name __________________________ **Last Name** _______________________________

Gender □ F □ M Birth Date_______/_______/_______ **Street Address** ____

City ____ **State** _______________________ **Zip code** ____________________

Home Phone (________) _________________ **Work Phone** (________) __________________ **Cell Phone** (_______) __________________

Signature of Responsible Party ____ **Date**_______________________________

Relationship (if not Patient) ____

The above information is true to the best of my knowledge. I certify that I have insurance with the insurance company(ies) disclosed and assign directly to Elite Foot and all insurance benefits, if any, otherwise payable to me for service(s) rendered. I understand that I am financially responsible for all charges whether or not paid by my insurance. I authorize the use of my signature below on all insurance submissions. Elite Foot and Ankle may use my health care information and may disclose such information to the disclosed insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

X____ ____________________
PATIENT/GUARDIAN SIGNATURE DATE

Elite Foot and Ankle • 210 Oakside Lane, Suite B • Canton, GA 30114
Phone: (770) 765-5828 • Fax: (678) 388-0977 • Website: EliteFootandAnkle.com

COMPREHENSIVE HEALTH REVIEW

Patient Name: ______________________________________ Date of Birth: ________________ Today's Date: ________________

HISTORY OF PRESENT ILLNESS / WHAT BRINGS YOU IN?

What is your specific foot/ankle problem? ____
____

When did the problem begin? ____________________________
The problem is: □Improving □Worsening □Unchanged
What aggravates the problem? ____________________________
What improves the problem? ____________________________

Which foot/ankle is involved? □Right □Left □Both
First visit to a doctor for this problem? □ Yes □No
Have you had a similar problem in the past? □ Yes □No
How was the problem onset? □ Sudden □ Gradual

The problem is worst: □AM □PM □At Rest □With Activity

Is the problem painful? □Yes □No
If so, rate your current pain: (none) 0 1 2 3 4 5 6 7 8 9 10 (worst)
Describe the pain:
□Sharp □Burning □ Clicking □Aching □Throbbing □Tingling
□Dull □Shooting □Cramping □Itching □Popping □Stabbing □Other: ____

Describe previous treatments: ____
Is this from an injury? □Yes □No If so, is it work-related? □Yes □No Describe: ____________________________________

PAST MEDICAL HISTORY

□Diabetes: Type □1 □2
Duration: ____ years
Last Blood Sugar _____ HbA1c ___
□Acid Reflux
□Anemia
□Anesthesia Complications
□Arthritis (Osteo / Rheum)
□Asthma
□Back Problems/Sciatica
□Blood Clot/DVT
□Cancer: ______________________
□Cellulitis/Skin Infection
□MRSA
□Circulation Problem

□Dementia/Alzheimer's
□Excessive/Easy Bleeding
□Fibromyalgia
□Foot/Leg Ulcer
□Gout
□Healing Problems/Keloids
□Heart Disease/Heart Attack
□High Blood Pressure (Low BP?)
□High Cholesterol
□Hormone Therapy
□Immune Disorder/HIV
□Kidney Disease (Dialysis)
□Other problems not listed:
□Liver Disease (Hepatitis)

□Leg Cramps/Leg Pain at Rest
□Lung Condition:
____
□Mitral Valve Prolapse/Murmur
□Multiple Sclerosis
□Nervous Disorder/Depression
□Neuropathy
□Osteomyelitis/Bone Infection
□Parkinson's Disease
□Previous Addiction to:
____
□Pulmonary Embolism
□Rashes/Skin Condition
□Raynauds Disease/Phenomena

□Seizure Disorder/Epilepsy
□Sickle Cell Disease/Trait
□Sleep Apnea
□Stomach Ulcers
□Stroke □Rt □Lt (year ______)
Thyroid Condition (□Hi □Lo)
□Varicose Veins
□**Women** – Are You?
□Pregnant or □Breast Feeding?
■Other problems not listed:
____
____

PAST SURGERIES

□Foot/Ankle Surgery: ________________
□Joint Replacement: ________________
□Open Heart/Bypass Surgery
□Hysterectomy: □Tubal ligation □C-Section
□Stent Placement: □Heart □Leg
□Cosmetic Surgery:________________
□Appendix □Gallbladder □Tonsils/Add
□Leg Bypass □Open Fracture Repair
□Carotid Surgery □Vein Surgery
□Hernia repair □Thyroid □Back surgery
□Other: ___________________________

FAMILY HISTORY

Mother **F**ather **S**ister **B**rother **G**rand**P**arent

Condition	Family member
Cancer	□M □F □S □B □GP
Diabetes	□M □F □S □B □GP
Gout	□M □F □S □B □GP
Heart Disease	□M □F □S □B □GP
High Blood Pressure	□M □F □S □B □GP
Severe Arthritis	□M □F □S □B □GP
Anesthesia Complications	□M □F □S □B □GP
Foot Problems	□M □F □S □B □GP
Other: ________________	□M □F □S □B □GP
Other: ________________	□M □F □S □B □GP

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COMPREHENSIVE HEALTH REVIEW

Patient Name: ______________________________________ Date of Birth: ________________ Today's Date: ________________

MEDICATIONS (include RX meds, OTC meds, and vitamins) - USE THE BACK OF SHEET IF NECESSARY

Medication	*Dosage*	*Medication*	*Dosage*
______________	______________	______________	______________
______________	______________	______________	______________
______________	______________	______________	______________
______________	______________	______________	______________

ALLERGIES

□None □Adhesives/Tape □Aspirin □Codeine □Cortisone □Sulfa Drugs
□Iodine □Latex □ Local Anesthetics □Penicillin □Seafood/Shellfish

SOCIAL HISTORY

Occupation: ____
□I Drink Alcoholic Beverages How much/often? _________
□I Use or Have Used Tobacco Products Type: __________________
Packs/Day _____ Years _____ When Stopped? __________________
□ I Use or Have Used Drugs that are Illegal_______________________
I Live With: □No One □Spouse □Children □Parents □Other

I Stand ______ % of My Day
I Exercise Each Week: □ 0 days □ 1-2 days □ 3+ days
List Sports/Activities: _______________________________________
____
□ My foot/ankle problem limits my activities
I am: □Single □Married □Divorced □Separated □Widowed

REVIEW OF SYSTEMS

CONSTITUTIONAL
□Recent Weight Changes Fever/Chills
□Nausea or Vomiting
□Fatigue

EYES
□Eye Disease/Injury
□Wear Glasses/Contacts
□Blurred or Double vision
□Glaucoma

EARS/NOSE/MOUTH/THROAT
□Hearing Loss
□Nose Bleeds
□Sore Throat/Voice Change
□Sinus Problems
□Difficulty Swallowing

CARDIOVASCULAR
□Chest Pain
□Palpitations
□Arrhythmia/Irregular Heartbeat
□Leg Pain when Walking
□Swelling of Hands/Feet

RESPIRATORY
□Shortness of Breath
□Chronic/Frequent Cough
□Wheezing

GENITOURINARY
□Frequent Urination
□Painful Urination
□Kidney Stones
□Blood in Urine

INTEGUMENTARY
□Rash or Itching
□Dry Skin
□Change in Hair/Nails

ENDOCRINE
□Hormonal Problem
□Excessive Thirst
□Excessive Urination
□Too Hot/Too Cold

NEUROLOGICAL
□Migraines
□Frequent Headaches
□Numbness/Tingling
□Dizzy Spells
□Paralysis/Tremors

PSYCHIATRIC
□Anxiety
□Depression
□Nervousness
□Insomnia
□Confusion/Memory Loss

MUSCULOSKELETAL
□Muscle Pain or Cramps
□Joint Pain
□Stiffness/Swelling Joints
□Low Back Pain
□Trouble Walking

GASTROINTESTINAL
□Indigestion/Heartburn
□Diarrhea
□Blood in Stools
□Stomach Pains

STATISTICS

Age ______ Height ________ Weight ________ Shoe Size _______

I understand that completing this paperwork is a chore. The information I have provided is true to the best of my knowledge. I recognize that the information I have provided will help me receive better care. I thank you for taking such an interest in my health.

X____ ____________
PATIENT/GUARDIAN SIGNATURE DATE

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SUMMARY NOTICE OF PRIVACY PRACTICES

Patient Name: ______________________________________ Date of Birth: ________________ Today's Date: ________________

The Notice of Privacy Practices contains a detailed description of how our office will protect your health information, your rights as a patient and our common practices in dealing with patient health information according to the Health Information Portability and Accountability Act (HIPAA).

Uses and Disclosures of Health Information. We will use and disclose your health information in order to treat you or to assist other health care providers in treating you. We will also use and disclose your health information in order to obtain payment for our services or to allow insurance companies to process insurance claims for services rendered to you by us or other health care providers. Finally, we may disclose your health information for certain limited operational activities such as quality assessment, licensing, accreditation and training of students.

Uses and Disclosures Based on Your Authorization. Except as stated in more detail in the Notice of Privacy Practices, we will not use or disclose your health information without your written authorization.

Uses and Disclosures Not Requiring Your Authorization. In the following circumstances, we may disclose your health information without your written authorization:

- To family members or close friends who are involved in your health care;
- For certain limited research purposes;
- For purposes of public health and safety;
- To Government agencies for purposes of their audits, investigations and other oversight activities;
- To Government authorities to prevent child abuse or domestic violence;
- To the FDA to report product defects or incidents;
- To law enforcement authorities to protect public safety or to assist in apprehending criminal offenders;
- When required by court orders, search warrants, subpoenas and as otherwise required by the law;
- To a collection agency and may provide protected health information to that agency in the event you do not satisfy your financial responsibilities.

Patient Rights. As our patient, you have the following rights:

- To have access to and/or a copy of your health information;
- To receive an accounting of certain disclosures we have made of your health information;
- To request restrictions as to how your health information is used or disclosed;
- To request that we communicate with you in confidence;
- To request that we amend your health information;
- To receive notice of our privacy practices.

If you have a question, concern or complaint regarding our privacy practices, please contact our office at (770)765-5828.

I, ______________________________ (Print Name of Patient or Legal Representative--**Patient DOB** ___________), acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read or had the opportunity to read if I so chose and understood the Notice. This authorization may be revoked by me at any time in writing. In addition, I authorize the following people access to my personal health information upon request (including leaving a detailed message): ☐ Spouse ☐ Other: Name/Relationship: ____
Leave a detailed message on these voicemails/cell: ____

____ _______________________
Signature of Patient or Legal Representative **Date**