PATIENT INFORMATION FORM

(PLEASE PRINT)

DATE ___/___/___

PATIENT NAME _____ DATE OF BIRTH ___/___/___ AGE: ___ SEX: M___ F___

LAST FIRST MI

HOME ADDRESS_____ CITY/STATE_____ ZIP_____

HOME PHONE NUMBER: (___) _____ CAN WE LEAVE MESSAGES? YES___ NO_____

WORK PHONE NUMBER: (___) _____ CAN WE LEAVE MESSAGES? YES___ NO_____

CELL PHONE NUMBER: (___) _____ CAN WE LEAVE MESSAGES? YES___ NO_____

EMAIL: _____

RACE: _____ ETHNICITY: HISPANIC NOT HISPANIC

PRIMARY LANGUAGE_____

DO YOU HAVE A LEGAL GUARDIAN OR HEALTHCARE POWER OF ATTORNEY? YES_____ NO _____

IF YES, NAME _____ RELATIONSHIP_____ PHONE (___) _____-_____

EMERGENCY CONTACT _____RELATIONSHIP _____ PHONE (___) ___-_____

PRIMARY CARE DOCTOR _____ PHONE (___) ___-_____

PHARMACY _____ PHONE (___) ___-_____

IS THERE A MEMBER OF YOUR FAMILY OR ANOTHER PERSON THAT WE CAN SHARE YOUR MEDICAL INFORMATION?

YES _____ NAME(S) _____

NO_____

WHO REFERRED YOU TO US _____

WHO IS RESPONSIBLE FOR PAYMENT _____ RELATIONSHIP TO PATIENT _____

ADDRESS_____ CITY/STATE _____ ZIP _____

INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY NAME _____

MEMBER ID _____ GROUP NUMBER _____

POLICY HOLDER'S NAME _____RELATIONSHIP TO POLICY HOLDER _____

SECONDARY INSURANCE COMPANY NAME _____

MEMBER ID _____ GROUP NUMBER _____

POLICY HOLDER'S NAME _____RELATIONSHIP TO POLICY HOLDER _____

PLEASE LIST ALL PRIOR SURGERIES

SURGERY DATE

_____

_____

_____

_____

_____

_____

PLEASE LIST ALL PRIOR HOSPITALIZATIONS (OTHER THAN FOR SURGERIES LISTED ABOVE)

HOSPITALIZATION DATE

_____

_____

_____

_____

_____

_____

SOCIAL HISTORY

MARITAL STATUS: SINGLE____ MARRIED ____ PARTNERED ____ SEPARATED ____ DIVORCED ____ WIDOWED ____

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

CURRENTLY USE _____ TYPE: _____ FREQUENCY: RARE _____ OCCASIONAL _____ DAILY_____

USE OF RECREATIONAL DRUGS: NEVER ____ QUIT _____ HOW LONG AGO _____ TYPE _____

USE CURRENTLY _____ TYPE _____

EMPLOYER: _____ OCCUPATION: _____

HOW MUCH ARE YOU ON YOUR FEET AT WORK? 10% ___ 25% ___ 50% ___ 75 % ___ 100% _____

DO OTHERS DEPEND UPON YOU FOR THEIR CARE? NO _____ YES _____

IF SO, WHO _____ RELATIONSHIP _____

PETS: NO _____ YES ____ IF SO, WHAT KIND _____

EXERCISE: NEVER ____ RARE ____ OCCASIONAL ____ DAILY ____ SEVERAL TIMES A WEEK ____ WEEKLY _____

TYPE OF EXERCISE: _____

FAMILY HISTORY

DO YOU HAVE A FAMILY HISTORY OF

DIABETES (TYPE 1 OR TYPE 2) ____ CANCER ____ HEART DISEASE ____ STROKE ____ HIGH BLOOD PRESSURE ____

CORONARY ARTERY DISEASE ____ THYROID DISEASE _____ RHEUMATOID ARTHRITIS ____ SKIN CANCER _____

IF SO, RELATIONSHIP TO PATIENT AND DISEASE TYPE

_____

_____

HAVE YOU EVER HAD ANY OF THE FOLLOWING:

ACID REFLUX		FIBROMYALGIA		NEUROPATHY	
ANEMIA		GOUT		OPEN SORES	
ARTHRITIS		HEART ATTACK		PNEUMONIA	
ASTHMA		HEART DISEASE/FAILURE		POLIO	
BACK TROUBLE		HEPATITIS		RHEUMATIC FEVER	
BLADDER INFECTIONS		HIV+/AIDS		SICKLE CELL DISEASE	
ABNORMAL BLEEDING		HIGH BLOOD PRESSURE		SKIN DISORDER	
BLOOD CLOTS		KIDNEY DISEASE		SLEEP APNEA	
BLOOD TRANSFUSION		LIVER DISEASE		STOMACH ULCERS	
BRONCHITIS/EMPHYSEMA		LOW BLOOD PRESSURE		STROKE	
CANCER		MIGRAINE HEADACHES		THYROID DISEASE	
DIABETES (1 OR 2)		MITRAL VALVE PROLAPSE		TUBERCULOSIS	

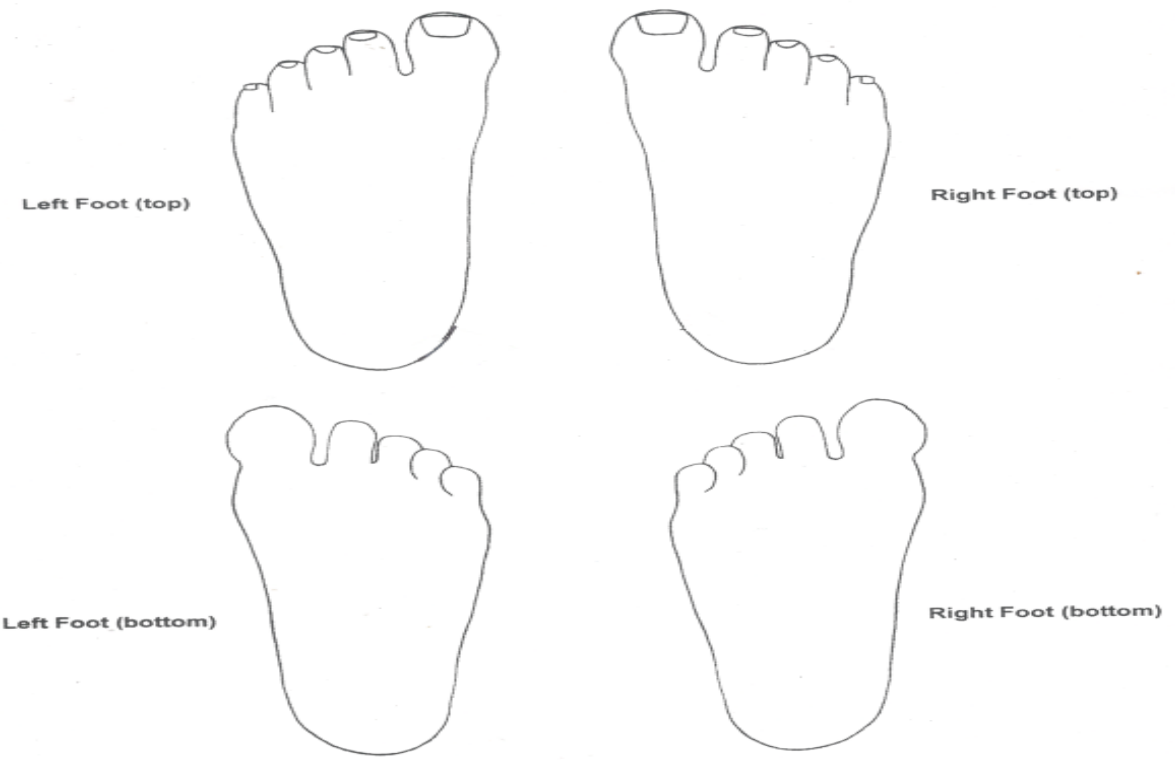
CURRENT PROBLEM

WHAT SPECIFIC PROBLEM BRING YOU TO OUR OFFICE TODAY?

_____

_____.

WHERE IS THE PAIN/PROBLEM LOCATED? PLEASE MARK THE ON THE PICTURES BELOW.



MY MEDICATION LIST

Patient Name: _____ Date: _____

Date of Birth: _____

Please list all drugs you are currently taking. Drugs include prescription and over the counter (OTC) medications, herbal products, nutritional supplements and recreational drugs.

Drug Name	Drug Strength	Amount and time per day	Reason	Prescriber

Do you have any drug allergies? _____ Yes _____No

If YES, please list:

_____

_____

_____

_____.

DISCLOSURE AND RELEASE AUTHORIZATION FORM

CONSENT TO TREAT: I request and give consent to my physician to provide and perform such medical/surgical care, tests, procedures, drugs and other services and supplies as my physician, in his/her professional judgment, deems necessary or beneficial. I acknowledge that no representations, warranties or guarantees as to the results or cures have been made to me or relied upon by me.

_____ **Initial**

RELEASE OF MEDICAL INFO AND AUTHORIZATION TO PAY INSURANCE BENEFITS: I authorize Charlotte County Foot and Ankle Clinics, PLLC (CCFAC) and my physician to release information from my medical records to my insurance carrier(s), governmental agency, or my employer in the case of work-related injuries, for the purpose of processing claims for medical/workers compensation benefits and state on such claims that my signature is on file. I request that my insurance company(s) honor my assignment of insurance benefits applicable to the services and pay all assigned insurance benefits directly to my physician, on my behalf.

_____ **Initial**

FINANCIAL AGREEMENT: I understand all accounts are the full responsibility of the patient and/or the patient's responsible party guarantor. My physician will assist patients in obtaining insurance benefits when those benefits are assigned to my physician. It is the patient's responsibility to make sure insurance payments are processed and paid promptly to my physician. In the case of default payment, I promise to pay any legal interest on the balance due, together with any collection costs and reasonable attorney fees incurred to effect collection of this account or future outstanding accounts.

_____ **Initial**

MEDICARE CERTIFICATION: I certify that the information given by me, or by CCFAC on my behalf, in applying for payment under Title XVIII of the Social Security Act is correct. I authorize my treating physician to release information from my medical record to the Social Security Administration and/or Medicare program or its intermediaries or carriers, or the Professional Standards Review Organizations for the purpose of processing of claims for medical benefits and state on such claims that my signature is on file. I request that payment of such authorized benefits be made directly to my treating physician on my behalf.

_____ **Initial**

E.PRESCRIBING CONSENT: I consent that CCFAC, DPM can request and use my prescription medication history from other healthcare providers and/or third party pharmacy benefit payors for treatment purposes.

_____ **Initial**

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES: I have received the Practice's Notice of Privacy Practices and understand that my protected health information maybe used by the Practice as described in the notice.

_____ **Initial**

Patient Name Print: _____ Date:_____

Patient/Guardian Signature: _____ Date:_____