



Welcome to our Office

Patient Information

First Name:	M.I.:	Last Name:		
<i>How would you like to be called:</i>		SS#:	DOB:	Age:
		<i>(REQUIRED)</i>		
Sex: M / F:	Marital Status:			
Address:	City:	State/Zip:		
Home Phone #	Cell Phone #			
Employer:	Address:	Work Phone #		
e-mail:		Pharmacy Phone #		

Emergency Contact Name:	
Relationship to patient:	Emergency Contact Phone:
How did you hear about Healthmark Foot and Ankle?	
Primary Care Physician:	Phone:
Address:	

Policy Holder Information Check if same as patient

First Name:	M.I.:	Last Name:	Sex: M / F
SS#:	DOB:	Home Phone #	Cell Phone #
Address:	City:	Zip:	
Employer:	Work Phone #		

Insurance Information

Primary Insurance Company Name:	
Policy/Contract No:	
Group No:	Effective Date:
Insurance Phone Number:	
Group Name:	Relationship to Insured: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other:
Secondary Insurance Company Name:	
Policy/Contract No:	
Group No:	Effective Date:
Insurance Phone Number:	
Group Name:	Relationship to Insured: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other:

Name: _____ DOB: _____

Guarantor Information (Check if same as patient)

First Name:	M.I.:	Last Name:	Sex: M / F
SS#:	DOB:	Home Phone#	Cell Phone #
Address:	City:		Zip:
Employer:	Work Phone #		

Assignment of Benefits / Authorization to Release Information & HIPAA Privacy Notice

If I am entitled to benefits under the Medicare, the Medicaid, or any insurance policy or other health benefit plan (covering me or anyone legally responsible for me), in consideration for services provided to me by Healthmark Foot & Ankle Associates, I assign, transfer and convey the benefits payable under such program, policy or plan for services rendered to me. I authorize payment of benefits directly to Healthmark Foot & Ankle Associates, with such benefits to be applied to my bill. **I understand and acknowledge that this assignment does not relieve me of financial responsibility for charges incurred by me or anyone on my behalf, and I hereby acknowledge responsibility for and agree to pay charges not paid under this assignment, including any coinsurance amounts, deductibles, Durable Medical Equipment and any charges for services deemed to be non-covered, not pre-certified or not pre-authorized by my insurance plan.**

_____ (*initial*) I give my consent for examination and treatment by Healthmark Foot & Ankle

_____ (*initial*) I acknowledge that I was provided a copy of the Notice of HIPAA Privacy Practices and that I have read (or had the opportunity to read) and understand the Notice.

_____ (*initial*) I acknowledge that I have received and read the Financial Policy of Healthmark Foot & Ankle Associates.

Responsible Party Signature _____

Relationship _____ **Date** ____/____/____

Witness _____ **Date** ____/____/____

I authorize the release of my medical information to the following parties ONLY:

Name _____ Relationship: _____

Name _____ Relationship: _____

Physician Signature _____ **Date** ____/____/____

Name: _____ DOB: _____ Date: _____

Review of Systems

(Please check all that applies)

GASTROINTESTINAL
<input type="checkbox"/> Poor Appetite
<input type="checkbox"/> Weight Loss
<input type="checkbox"/> Weight Gain
<input type="checkbox"/> Excessive Hunger
<input type="checkbox"/> Excessive Thirst
<input type="checkbox"/> Nausea
GENTOURINARY
<input type="checkbox"/> Frequent Urination
<input type="checkbox"/> Painful Urination
<input type="checkbox"/> Kidney Stones
NEUROLOGICAL
<input type="checkbox"/> Weakness
<input type="checkbox"/> Dizziness
<input type="checkbox"/> Numbness
<input type="checkbox"/> Paralysis
<input type="checkbox"/> Fainting
EYES
<input type="checkbox"/> Blurred Vision
<input type="checkbox"/> Eye Inflammation
<input type="checkbox"/> Impaired Site
EARS / NOSE / THROAT
<input type="checkbox"/> Hearing Loss
<input type="checkbox"/> Ear Discharge
<input type="checkbox"/> Nose Bleeding
<input type="checkbox"/> Nose Discharge
<input type="checkbox"/> Sore Throat
CARDIOVASCULAR
<input type="checkbox"/> Chest Pain
<input type="checkbox"/> Feet / Leg Swelling
<input type="checkbox"/> Leg Pain / Cramping
<input type="checkbox"/> Rapid Heart Beat
MUSCULOSKELATAL
<input type="checkbox"/> Joint Pain / Stiffness
<input type="checkbox"/> Muscle Pain
RESPIRATORY
<input type="checkbox"/> Persistent Cough
<input type="checkbox"/> Wheezing
<input type="checkbox"/> Difficulty Breathing
<input type="checkbox"/> Shortness of Breath
INTEGUMENTARY
<input type="checkbox"/> Itching
<input type="checkbox"/> Skin Rash
<input type="checkbox"/> Deformed Nails
<input type="checkbox"/> Ulcerations
HEMATOLOGIC
<input type="checkbox"/> Bleeding Disorder
<input type="checkbox"/> Taking Coumadin

Past Medical History

(Please check all that applies)

<input type="checkbox"/> DIABETES
<input type="checkbox"/> Glaucoma
<input type="checkbox"/> Stroke/TIA
<input type="checkbox"/> Heart Attack/MI
<input type="checkbox"/> Atrial Fibrillation
<input type="checkbox"/> High Cholesterol
<input type="checkbox"/> High Blood Pressure
<input type="checkbox"/> Seizure Disorder
<input type="checkbox"/> Kidney Disease
<input type="checkbox"/> Kidney Stones
<input type="checkbox"/> Prostate Problems
<input type="checkbox"/> Liver Disease/Hepatitis
<input type="checkbox"/> Asthma
<input type="checkbox"/> Gout
<input type="checkbox"/> Raynaud's Disease
<input type="checkbox"/> Ulcerative Colitis
<input type="checkbox"/> Crohn's Disease
<input type="checkbox"/> Osteoarthritis
<input type="checkbox"/> Rheumatoid Arthritis
<input type="checkbox"/> Back / Spine Problems
<input type="checkbox"/> Fibromyalgia
<input type="checkbox"/> Anemia
<input type="checkbox"/> HIV / AIDS
<input type="checkbox"/> Cancer - type:
<input type="checkbox"/> Anxiety
<input type="checkbox"/> Depression
<input type="checkbox"/> Alcohol Abuse
<input type="checkbox"/> Drug Abuse
<input type="checkbox"/> Thyroid Disorder
<input type="checkbox"/> Reflux / GERD
<input type="checkbox"/> Lyme Disease
<input type="checkbox"/> Osteopenia / Osteoporosis
<input type="checkbox"/> Other medical problems:

Please list all previous surgeries and hospitalizations:

ALLERGIES/REACTION:

<input type="checkbox"/> NONE
<input type="checkbox"/> Penicillin
<input type="checkbox"/> Sulfa
<input type="checkbox"/> LATEX
<input type="checkbox"/> Iodine/Shellfish
<input type="checkbox"/> Tape
<input type="checkbox"/> Local Anesthesia
<input type="checkbox"/> Other:

SOCIAL HISTORY:

<input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Partnered
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced
Have you ever used illicit drugs? <input type="checkbox"/> Y <input type="checkbox"/> N
Do you ever drink alcohol? <input type="checkbox"/> Y <input type="checkbox"/> N
Do you use tobacco? <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Quit

List or attach a complete list of all current Medications and Supplements:

Are there any diseases / illnesses that seem common or run in your family? _____

To the best of my knowledge, I have answered the questions on this form as accurately as possible. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor and the staff of any changes in my medical status.

Print Name of Patient

Signature of Patient/Parent/Guardian

Date

Signature of Doctor

Date

Name: _____ Date: _____ DOB: _____

Please list any specific problems you want to discuss with the doctor?

How long have you had this problem?

What is the nature of your pain? Sharp Dull Aching Burning Radiating Itching
Stabbing Other _____

Is there a history of injury? Y N Date of injury? _____

Is your condition getting better or worse? _____

Rate your pain: (Please circle one) **0 1 2 3 4 5 6 7 8 9 10** (severe)

What seems to make the condition / pain worse?

What seems to make the condition / pain better?

Have you seen any other physician for this problem?

Please list any treatments you have had for this condition:

Has this condition affected your ability to work, exercise or perform other daily activities?

Y N

If so, how? _____

Do you currently or have you previously used:

Corrective shoes Ankle braces Orthotics

Date Last Seen by your Primary Care Physician: _____

Height: _____ **Weight:** _____