

PLEASE PRINT

NAME: _____ DATE OF BIRTH: ____/____/____ AGE: _____
ADDRESS: _____ APT _____ CITY _____ STATE _____ ZIP _____
SEX M F MARITAL STATUS _____ DRIVER'S LICENSE # _____
SOCIAL SECURITY # ____-____-____ PARENT OR GUARDIAN _____
EMERGENCY CONTACT _____ PHONE# _____ RELATION _____
PHARMACY _____ PHONE# _____

CONTACT INFORMATION - MAY WE LEAVE A MESSAGE?

HOME# ____-____-____ YES OR NO WORK# ____-____-____ YES OR NO
CELL# ____-____-____ YES OR NO EMAIL _____
EMPLOYER _____ OCCUPATION _____
ADDRESS _____ CITY _____ STATE _____ ZIP _____

INSURANCE INFORMATION

MEDICAL INSURANCE _____ ID# _____ GROUP/POLICY _____
OTHER INSURANCE _____ ID# _____ GROUP/POLICY _____
NAME OF POLICY HOLDER _____ DATE OF BIRTH ____/____/____ SS# ____-____-____
IS THIS A WORK RELATED INJURY? YES OR NO If YES, DATE OF ACCIDENT ____/____/____
PLACE OF ACCIDENT _____ CLAIM # _____ ADJUSTOR _____

WHOM MAY WE THANK FOR REFERRING YOU TO THIS OFFICE?

DOCTOR _____ PHONE# _____
ADDRESS _____ CITY _____ STATE _____ ZIP _____
INTERNET SEARCH ENGINE? _____ FRIEND? _____

MEDICAL INFORMATION

PRIMARY CARE PHYSICIAN _____ PHONE# _____
ADDRESS _____ CITY _____ STATE _____ ZIP _____

LIST ANY SURGERIES AND/OR HOSPITALIZATIONS

<i>PROCEDURE</i>	<i>DATE</i>
_____	_____
_____	_____
_____	_____

LIST ALL MEDICATIONS (BOTH PRESCRIBED AND OVER THE COUNTER) AND SUPPLEMENTS

<i>MEDICATION</i>	<i>FREQUENCY</i>	<i>MEDICATION</i>	<i>FREQUENCY</i>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

PATIENT NAME: _____ D.O.B ____/____/____

ALLERGIES: PLEASE LIST

ANTIBIOTICS: PENICILLIN SULFA KEFLEX

PAIN MEDS: CODEINE MORPHINE ASPIRIN NSAIDS

OTHER: SHELLFISH IODINE ADHESIVE TAPE GENERAL / LOCAL ANES.

REVIEW OF SYSTEMS: PLEASE CIRCLE ALL THAT APPLY

MAJOR ILLNESSES: DIABETES **YES OR NO** - IF DIABETIC HOW LONG _____ IS IT WELL MAINTAINED? **YES OR NO** / ARTHRITIS -WHAT TYPE _____

HEART DISEASE / HYPERTENSION / CHEST PAIN ANGINA / MI / CANCER / MITRAL VALVE PROLAPSE / MURMUR / ARRHYTHMIA / STROKE / CHF / PACEMAKER

RESPIRATORY: ASTHMA / BRONCHITIS / EMPHYSEMA / SINUS PROBLEMS/ INFECTIONS / SHORTNESS OF BREATH/ COPD / LUNG DISEASE OR BREATHING PROBLEMS / TUBERCULOSIS / SMOKER

EENT: SINUS PROBLEMS OR INFECTIONS / TONSILLITIS / THROAT INFECTIONS / GLAUCOMA /CATARACTS / EYE OR VISION PROBLEMS / HEADACHES / MIGRAINES / HEARING DEFICIT

GASTROINTESTINAL: ULCERS / REFLUX / HIATAL HERNIA / STOMACH DISORDER /BOWEL DISORDER / IRRITABLE BOWEL SYN. / HEMORRHOIDS / LIVER DISEASE

GENITO-URINARY: KIDNEY OR BLADDER INFECTIONS / KIDNEY STONES / PROSTATE / STD

VASCULAR DISEASE/BLOOD DISORDERS: POOR CIRCULATION / PVD / LEG OR CALF PAIN / NIGHT CRAMPS / REST PAIN / VEIN PROBLEMS / SWELLING / SPIDER VEINS / VARICOSE VEINS / PHLEBITIS / LEG ULCERS / BLOOD CLOTS / DVT/ PE / BLEEDING OR CLOTTING DISORDERS / EASY BRUISING / ANEMIA / SICKLE CELL / TRANSFUSIONS /HEART ATTACK/ HIGH BLOOD PRESSURE/ LOW BLOOD PRESSURE/

OTHER: _____

ARTHRITIS: RHEUMATOID / OSTEO / GOUT / OTHER ARTHRITIS

SKIN DISORDERS: PSORIASIS / SKIN CANCER/OPEN WOUNDS

PSYCHOLOGICAL: ANXIETY / DEPRESSION / PSYCHIATRIC CONDITION / DRUG OR ALCOHOL DEPENDENCY/BIPOLAR/

Misc. ILLNESSES: EPILEPSY OR SEIZURES / THYROID DISEASE / MUSCLE DISEASE / FIBROMYALGIA/HEPATITIS / HIV OR AIDS / PREGNANCY - CHILDBIRTH / BACK TROUBLE/NEUROPATHY/POLIO/RHEUMATIC FEVER

OTHER: _____

SOCIAL & FAMILY HISTORY

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

FREQUENCY: _____#DRINKS PER _____ MONTH/ WEEK/ DAY

USE OF TOBACCO: NEVER NO LONGER USE CURRENT USER

FREQUENCY: _____#CIGARETTES PER _____ MONTH/ WEEK/ DAY

USE OF RECREATIONAL DRUGS: NEVER NO LONGER USE CURRENT USER

FREQUENCY: _____#TIMES PER _____ MONTH/ WEEK/ DAY

DO YOU HAVE A FAMILY HISTORY OF: DIABETES CANCER HEART DISEASE HIGH BLOOD

PRESSURE STROKE CORONARY ARTERY DISEASE THYROID RHEUMATOID ARTHRITIS

OTHER _____

PATIENT NAME: _____ D.O.B: ____/____/____

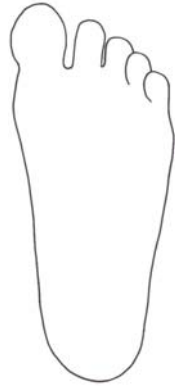
Current problem(s): If you have more than one problem -please request additional sheet(s)

WHERE IS THE PAIN/PROBLEM LOCATED? PLEASE MARK ON THE PICTURES BELOW USING X'S.

LEFT FOOT

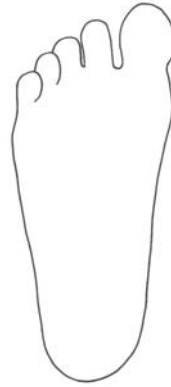


TOP OF FOOT

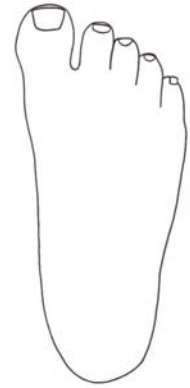


BOTTOM OF FOOT

RIGHT FOOT



BOTTOM OF FOOT



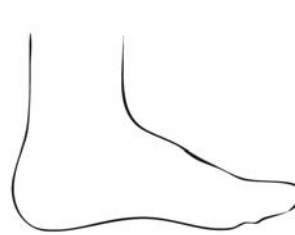
TOP OF FOOT



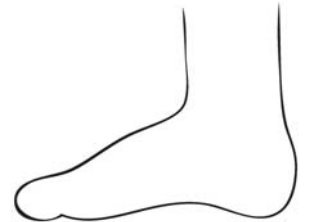
INSIDE OF FOOT



OUTSIDE OF FOOT



OUTSIDE OF FOOT



INSIDE OF FOOT

PROBLEM(S) : _____

WAS THIS PROBLEM CAUSED BY AN INJURY? YES NO

(DESCRIBE) _____

IF YES, WAS IT A WORK-RELATED INJURY? YES NO

HOW LONG AGO DID THIS PROBLEM FIRST START? _____ DAYS / WEEKS / MONTHS / YEARS

DID YOUR PAIN OR PROBLEM: BEGIN ALL OF A SUDDEN GRADUALLY DEVELOP OVER TIME

HOW WOULD YOU DESCRIBE YOUR PAIN? NO PAIN SHARP DULL ACHING BURNING
 RADIATING ITCHING STABBING OTHER _____

HOW WOULD YOU RATE YOUR PAIN ON A SCALE FROM 0 TO 10? (PLEASE CIRCLE)

(NO PAIN) 0 1 2 3 4 5 6 7 8 9 10 (WORST)

WHAT MAKES YOUR PAIN OR PROBLEM FEEL WORSE? WALKING STANDING DAILY ACTIVITIES
 RESTING DRESS SHOES HIGH HEELS WORSE AT NIGHT OR SLEEPING
 ANY CLOSED TOE SHOE RUNNING OTHER _____

WHAT MAKES YOUR PAIN OR PROBLEM FEEL BETTER?

REFERRAL POLICY

If your insurance is a part of Managed Care plan (HMO, POS, EPO, etc.), failure to obtain a valid referral from your primary care physician (PCP) may result in reduced or no benefits being paid

Non-Covered Foot Care

Your insurance carrier may determine that your foot care is an excluded service, in which case no reimbursement will be made. Should this occur, the responsibility of payment will remain yours as the recipient of these services. (This includes orthotics, splints, over the counter medications, heel cups, pads, toe separators, i.e., anything that is given to you in this office that your carrier may not pay).

HIPPA Notice

I authorize use of this form on all my insurance submissions and release of information to all my insurance companies. I acknowledge responsibility for payment of any deductible, co-insurance, and unauthorized or non-covered services. I accept responsibility for any unpaid bills sixty days after insurance is filed. If for any reason the account becomes delinquent, I agree to pay for all collection and legal fees. I authorize the doctors of Metroplex Foot & Ankle, L.L.P. to act as my agents in helping me obtain payment from my insurance company. I request payment of my insurance benefits be made directly to Metroplex Foot & Ankle, L.L.P. for any services physicians of Metroplex Foot & Ankle, L.L.P. to examine and administer treatment after consultation and perform such procedures as be deemed necessary in the diagnosis and/ or treatment of my condition.

ACKNOWLEDEMENT OF RECEIPT OF PRIVACY NOTICE

We are required by law to provide you with a copy of our Notice of Privacy Practices. To ensure that our records are accurate, please sign this form to acknowledge that you have been provided with a copy of our notice.

TO THE BEST OF MY KNOWLEDGE, I HAVE ANSWERED THE QUESTIONS ON THIS FORM ACCURATELY. I UNDERSTAND THAT PROVIDING INCORRECT INFORMATION CAN BE DANGEROUS TO MY HEALTH. I UNDERSTAND THAT IT IS MY RESPONSIBILITY TO INFORM THE DOCTOR AND OFFICE STAFF OF ANY CHANGES IN MY MEDICAL STATUS.

PRINT NAME OF PATIENT OR LEGAL REPRESENTATIVE

SIGNATURE OF PATIENT OR LEGAL REPRESENTATIVE

DATE