East Village
Foot & Ankle
SURGEONS

PATIENT INFORMATION

(PLEASE PRINT)

General Information

Today's Date: _____ Date of Birth: _____ ☐ Male ☐ Female

Patient Name: Last _____ First _____ M.I. ____ Nickname _____

Home Address: _____

City: _____ State: _____ Zip: _____

Social Security #: _____ - _____ - _____

Home Phone #: _____ Work Phone #: _____

Cell Phone #: _____ E-mail: _____

Primary Language: _____ Ethnicity: Hispanic or Non-Hispanic Race: _____

Emergency Contact: _____ Relationship: _____ Phone #: _____

Primary Care Doctor: _____ Date Last Seen: _____

Cardiologist: _____ Other Physicians: _____

Pharmacy: _____ Location: _____

Who referred you to us / How did you hear about us?: _____

Insurance Information

Primary Insurance Company Name: _____

Secondary Insurance Company Name: _____

Social History

Marital Status: ☐ Single ☐ Married ☐ Partnered ☐ Separated ☐ Divorced ☐ Widowed

Employer: _____ Occupation: _____

Use of Alcohol: ☐ Never ☐ Rare ☐ Moderate ☐ Daily ☐ History of alcohol abuse

Use of Tobacco: ☐ Never ☐ Quit – how long ago: _____ ☐ Smokeless/Chewing Tobacco

☐ Smoke _____ packs per day for _____ years

Use of Recreational Drugs: ☐ No ☐ Yes, Type: _____

Family History

Father - Birth date: _____ Death date: _____ Illnesses: _____

Mother - Birth date: _____ Death date: _____ Illnesses: _____

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MEDICAL HISTORY

HEIGHT: _____ FT _____ IN WEIGHT: _____ LBS SHOE SIZE: _____

ARE YOU CURRENTLY TAKING AN ANTIBIOTIC: _____ IF YES, WHAT MEDICATION: _____

DIABETES: ☐ NOT APPLICABLE ☐ TYPE 1 ☐ TYPE 2 FASTING BLOOD SUGAR: _____ LAST A1C: _____

BLOOD THINNER: ☐ NOT APPLICABLE ☐ ASPIRIN ☐ OTHER (WARFARIN/COUMDADIN/PLAVIX/ELIQUIS/XARELTO/ETC.)

ALLERGIES: ☐ NONE KNOWN ☐ TAPE ☐ LATEX ☐ IODINE ☐ ANESTHESIA

☐ FOODS IF YES, WHAT: _____ ☐ OTHER: _____

ALLERGY TO MEDICATION(S): _____

PLEASE LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING (INCLUDE PRESCRIPTIONS, OVER-THE-COUNTER MEDS & HERBAL SUPPLEMENTS):

NAME DOSE HOW OFTEN DO YOU TAKE?

_____

_____

_____

IF NECESSARY, PLEASE USE AN ADDITIONAL PAGE OR WE CAN TO TAKE A COPY OF YOUR MEDICATION LIST FOR OUR RECORDS.

PLEASE LIST ALL PRIOR SURGERIES:

TYPE OF SURGERY DATE TYPE OF SURGERY DATE

_____ _____

_____ _____

HAVE YOU EVER HAD ANY OF THE FOLLOWING?

ACID REFLUX	Y	N	FIBROMYALGIA	Y	N	NEUROPATHY	Y	N
ANEMIA	Y	N	GOUT	Y	N	OPEN SORES	Y	N
ARTHRITIS	Y	N	HEART ATTACK	Y	N	PNEUMONIA	Y	N
ASTHMA	Y	N	HEART DISEASE/FAILURE	Y	N	POLIO	Y	N
BACK TROUBLE	Y	N	HEPATITIS	Y	N	RHEUMATIC FEVER	Y	N
BLADDER INFECTIONS	Y	N	HIV+/AIDS	Y	N	SICKLE CELL DISEASE	Y	N
ABNORMAL BLEEDING	Y	N	HIGH BLOOD PRESSURE	Y	N	SLEEP APNEA	Y	N
BLOOD CLOTS	Y	N	KIDNEY DISEASE	Y	N	STOMACH ULCERS	Y	N
BLOOD TRANSFUSION	Y	N	LIVER DISEASE	Y	N	STROKE	Y	N
CANCER	Y	N	LOW BLOOD PRESSURE	Y	N	THYROID DISEASE	Y	N
DIABETES	Y	N	LUNG DISEASE	Y	N	TUBERCULOSIS	Y	N
OTHER CONDITIONS:								

PATIENT NAME: _____ DOB: _____

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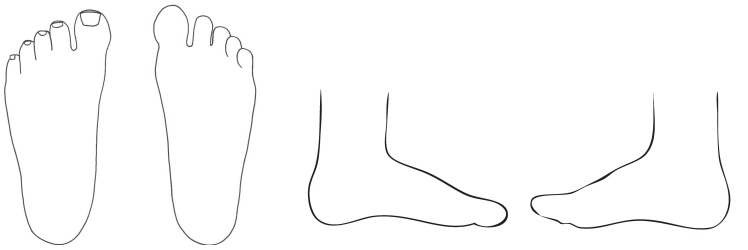
CURRENT PROBLEM

WHAT SPECIFIC PROBLEM BRINGS YOU TO OUR OFFICE TODAY: _____

_____

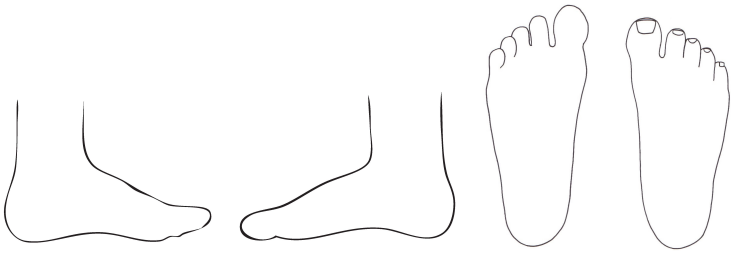
WHERE IS THE PAIN/PROBLEM LOCATED? PLEASE MARK ON THE PICTURES BELOW.

LEFT FOOT



TOP BOTTOM INSIDE OUTSIDE

RIGHT FOOT



OUTSIDE INSIDE BOTTOM TOP

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

DESCRIBE YOUR PAIN: ☐ NO PAIN ☐ SHARP ☐ DULL ☐ ACHING ☐ BURNING

☐ RADIATING ☐ THROBBING ☐ 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 PAIN POSSIBLE)*

SINCE THE TIME YOUR PAIN OR PROBLEM BEGAN, HAS IT: ☐ STAYED THE SAME ☐ BECOME WORSE ☐ IMPROVED

WHAT MAKES YOUR PAIN OR PROBLEM FEEL WORSE: ☐ DAILY ACTIVITY ☐ WALKING ☐ EXERCISE

☐ STANDING ☐ SHOE WEAR ☐ RESTING ☐ OTHER: _____

WHAT MAKES YOUR PAIN OR PROBLEM FEEL BETTER: _____

WHAT TREATMENTS HAVE YOU HAD FOR THIS PROBLEM: _____

WAS THIS PROBLEM CAUSED BY AN INJURY: ☐ NO ☐ YES IF YES, WAS IT A WORK-RELATED INJURY? ☐ NO ☐ YES

ADDITIONAL INFORMATION

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, PARENT, GUARDIAN, OR LEGAL REPRESENTATIVE

IF OTHER THAN PATIENT, RELATIONSHIP TO PATIENT

_____ _____

SIGNATURE

DATE

PATIENT NAME: _____ DOB: _____

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CONSENT TO TREAT/PAYMENT AUTHORIZATION & NOTICE OF PRIVACY PRACTICES

TODAY'S DATE: _____

PATIENT NAME: _____ _____ _____ BIRTHDATE: _____
LAST FIRST M.I.

CONSENT TO TREAT/PAYMENT AUTHORIZATION:

1) I AUTHORIZE THE HEALTHCARE PROVIDERS OF **EAST VILLAGE FOOT & ANKLE SURGEONS** TO ADMINISTER TREATMENT AS DEEMED NECESSARY FOR CARE OF THE PATIENT NAMED ABOVE. I CERTIFY THAT, IF I AM NOT THE PATIENT, I AM THE LEGAL GUARDIAN OF THE PATIENT. I ALSO CERTIFY THAT NO GUARANTEE OR ASSURANCE HAS BEEN MADE AS TO THE RESULTS THAT MAY BE OBTAINED FROM THE TREATMENT.

2) I CERTIFY THAT I HAVE READ AND UNDERSTAND THE INFORMATION PROVIDED TO ME ON THIS DATE TO THE BEST OF MY ABILITY. THE QUESTIONS ASKED VERBALLY AND IN WRITING HAVE BEEN OR WILL BE ACCURATELY ANSWERED. I UNDERSTAND THAT PROVIDING INCORRECT INFORMATION CAN BE DANGEROUS TO MY HEALTH.

3) I AUTHORIZE THIS OFFICE TO RELEASE ANY INFORMATION INCLUDING DIAGNOSIS AND THE RECORDS OF ANY TREATMENT OR EXAMINATION RENDERED TO ME OR MY CHILD DURING THE PERIOD OF SUCH PHYSICIAN CARE TO THIRD PARTY PAYERS AND/OR HEALTH PRACTITIONERS. I AUTHORIZE AND REQUEST MY INSURANCE COMPANY TO PAY DIRECTLY TO THIS OFFICE ANY BENEFITS FOR OUR SERVICES THAT MAY OTHERWISE BE PAYABLE TO ME. I UNDERSTAND THAT MY INSURANCE CARRIER MAY PAY LESS THAN THE ACTUAL BILL FOR SERVICES. ALL PROFESSIONAL SERVICES RENDERED ARE CHARGED TO THE PATIENT. NECESSARY FORMS WILL BE COMPLETED TO HELP EXPEDITE INSURANCE CARRIER PAYMENTS. THE PATIENT/PARENT/RESPONSIBLE PARTY IS RESPONSIBLE FOR ANY UNPAID BALANCES. CO-PAYMENTS WILL BE MADE AT THE TIME OF SERVICE. I REQUEST THAT PAYMENT OF AUTHORIZED MEDICARE, MEDICAID, OR OTHER INSURANCE COMPANY BENEFITS BE MADE TO THE CARE PROVIDERS OF **EAST VILLAGE FOOT & ANKLE SURGEONS** FOR ANY SERVICES FURNISHED TO ME BY THE OFFICE. REGULATIONS PERTAINING TO MEDICARE AND MEDICAID ASSIGNMENT OF BENEFITS APPLY.

_____
SIGNATURE OF PATIENT OR LEGAL REPRESENTATIVE

IF PATIENT IS UNDER THE AGE OF 18, FULL NAME OF PARENT OR LEGAL REPRESENTATIVE: _____

ADDRESS (IF DIFFERENT THAN YOUR OWN): _____

CITY: _____ STATE: _____ ZIP CODE: _____ PH #: _____

ACKNOWLEDGMENT OF NOTICE OF PRIVACY

MY SIGNATURE BELOW INDICATES THAT I HAVE BEEN GIVEN AN OPPORTUNITY TO READ EAST VILLAGE FOOT & ANKLE SURGEONS' NOTICE OF PRIVACY PRACTICES AND TO HAVE ANY QUESTIONS ANSWERED BEFORE SIGNING. PLEASE NOTIFY US IF YOU HAVE OR ARE A LEGAL GUARDIAN OR HEALTHCARE POWER OF ATTORNEY.

_____ _____
SIGNATURE OF PATIENT OR LEGAL REPRESENTATIVE DATE

PRINT NAME: _____

IF SIGNED BY SOMEONE OTHER THAN PATIENT, PLEASE INDICATE RELATIONSHIP TO PATIENT:

- ☐ PARENT OR GUARDIAN OF MINOR PATIENT
- ☐ GUARDIAN OR CONSERVATOR OF AN INCOMPETENT PATIENT
- ☐ BENEFICIARY OR PERSONAL REPRESENTATIVE OF DECEASED PATIENT

FOR OFFICE USE ONLY: EMPLOYEE SIGNATURE: _____ DATE: _____

- ☐ EFFORTS TO OBTAIN:
- ☐ REASON PATIENT REFUSED TO SIGN:

PATIENT NAME: _____ DOB: _____