

PATIENT RECORD

TODAYS DATE _____

Account # _____

Please fill out completely

Location: _____ (1/2010) PG 1

Dr. _____

Patients full name:

Last _____ First _____ MI _____ Sex M F

Patient SS # _____ Date of Birth _____

Marital Status S M D W Name of Spouse _____

Phone _____ Work _____ Cel _____

Local Address _____

City _____ State _____ Zip _____

Second or out of state Address _____

City _____ State _____ Zip _____

Pharmacy # _____ E-Mail _____

Employer Name _____ Job Title _____

Company Phone _____ Address _____

How did you hear about us? _____ If referred, by whom? _____

Name and **relationship** of Emergency Contact _____

Phone number of Emergency Contact _____

Name of Family Physician _____ Date last seen: _____

Phone _____ Fax _____

Address _____

SIGNATURE OF RESPONSIBLE PARTY

DATE

Person responsible for services rendered if different than listed above

Name _____ SS# _____

Address _____

Phone _____ DOB _____

Social History – Do you:

Smoke tobacco smoke marijuana use hallucinogenic drugs
Drink alcohol use cocaine use other recreational drugs

Alcohol, number of drinks

Number of drinks a day _____ greater than 5 per day _____ 1-3 drinks per week
4-6 drinks per week occasional use social drinking only week end drinking only

Social Smoker, number of packs a day

_____ number of packs per day 5 or more packs per day 1-2 packs per day 3-4 packs per week
Occasional smoking only weekend only

If you use other recreational drugs – please list / specify :

Medication – please list medications (including aspirin) currently taking:

Allergies – Do you have allergies to any of the following:

No Known allergies

Penicillin Erythromycin sulfa codeine

Aspirin cortisone adhesive tape

Local anesthetics iodine latex

Other allergies to medications – please list:

What is your height?

What is your weight?

What is your Shoe size and width?

Please describe what brings you to the office today?

Name of Primary Care / Family Physician (first and last name) ?

Date last seen by Primary Care / Family Physician (month, day and year if known)

Past medical history:

hypertention/high blood pressure HIV/AIDS hepatitis heart attack/MI
 insulin dependent diabetes non insulin dependent diabetes stroke/CVA aneurysm
 blood clot

Past medical history – injuries/trauma

Have you had any of the following foot surgeries:

toenail bunion hammertoe fracture repair joint fusions
 tendon repair/rerouting ankle stabilization arthroscopy fasciotomy

Please list approximate month and year of any surgery listed above:

Past Surgical History: Have you had any of the following surgeries?

heart bypass heart valve repair/replacement appendectomy
 gallbladder brain surgery other

Please list approximate month and year of any surgery listed above:

Any other surgeries? (Please specify type of surgery and date)

HEALTH QUESTIONNAIRE

PATIENTS NAME: _____ HEIGHT _____ WEIGHT _____ SHOE SIZE _____

TYPE FOOT PROBLEM _____

HOW LONG HAS IT BEEN A PROBLEM _____

HAVE YOU HAD ANY TREATMENT FOR THE ABOVE PROBLEM? _____

HISTORY OF PAST ILLNESS: HAVE YOU HAD? : IF YES PLEASE EXPLAIN BELOW

ARTHRITIS OR BURSITIS	NO	YES	_____
ANEMIA	NO	YES	_____
BACK PROBLEMS	NO	YES	_____
DIABETES	NO	YES	_____
STROKES	NO	YES	_____
CANCER	NO	YES	_____
THYROID	NO	YES	_____
STOMACH ULCERS	NO	YES	_____
HEPATITIS/LIVER	NO	YES	_____
HIV/AIDS	NO	YES	_____
ASTHMA/RESPIRATORY	NO	YES	_____
HIGH BLOOD PRESSURE	NO	YES	_____
RHEUMATIC FEVER	NO	YES	_____
BLEEDING DISORDER	NO	YES	_____
HEAD INJURIES	NO	YES	_____

PLEASE LIST ANY OTHER ILLNESS YOU ARE UNDER CARE OF A DOCTOR OR BEEN HOSPITALIZED INCLUDING SURGIES:

FAMILY HISTORY:

CANCER	NO	YES
DIABETES	NO	YES
HEART TROUBLE	NO	YES
HIGH BLOOD PRESSURE	NO	YES
STROKE	NO	YES
BLEEDING TENDENCY	NO	YES
GOUT ARTHRITIS	NO	YES

ALCOHOL BEVERAGES _____ NEVER _____ RARELY _____ MODERATELY _____
TOBACCO: HAVE YOU EVER SMOKED NO YES _____ PACKS A DAY _____ YEARS

List All Medications:

LIST ALL ALLERGIES:

PATIENT RECORD OF DISCLOSURES

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

I wish to be contacted in the following manner (check all that apply):

<input type="checkbox"/> Home Telephone _____ <input type="checkbox"/> O.K. to leave message with detailed information <input type="checkbox"/> Leave message with call-back number only	<input type="checkbox"/> Written Communication <input type="checkbox"/> O.K. to mail to my home address <input type="checkbox"/> O.K. to mail to my work/office address <input type="checkbox"/> O.K. to fax to this number
<input type="checkbox"/> Work Telephone _____ <input type="checkbox"/> O.K. to leave message with detailed information <input type="checkbox"/> Leave message with call back number only	<input type="checkbox"/> Other: _____

_____	_____
Patient Signature	Date
_____	_____
Print Name	Birthdate

The Privacy Rule generally requires healthcare providers to take reasonable steps to limit the use of disclosure of, and requests for PHI to the minimum necessary to accomplish the intended purpose. These provisions do not apply to uses or disclosures made pursuant to an authorization requested by the individual.

Healthcare entities must keep records of PHI disclosures. Information provided below, if completed properly, will constitute an adequate record.

Note: Uses and disclosures for PHI may be permitted without prior consent in an emergency.

Record of Disclosures of Protected Health Information

Date	Disclosed to Whom Address or Fax Number	(1)	Description of Disclosure/ Purpose of Disclosure	By Whom Disclosed	(2)	(3)

(1) Check this box if the disclosure is authorized
 (2) Type key: T=Treatment Records; P=Payment Information; O=Healthcare Operations
 (3) Enter how disclosure was made: F=Fax; P=Phone; M=Mail; O=Other