

PATIENT INFORMATION AND MEDICAL HISTORY

MRS MISS MS MR MASTER MISTER

SPOUSE NAME: _____

PATIENT'S NAME _____ SS# OF PATIENT _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

DATE OF BIRTH _____ AGE _____ HOME PHONE# _____

CELL# _____ MSG/EMERGENCY# _____ NAME _____

YOUR EMPLOYER _____ BUSINESS # _____

SPOUSE'S EMPLOYER _____ SPOUSE'S DOB _____ SS# _____

RESPONSIBLE PARTY NAME _____ PHONE _____ RELATIONSHIP _____

RESPONSIBLE PARTY'S ADDRESS _____ CITY _____ STATE _____ ZIP _____

THEIR SS# _____ DOB _____ EMPLOYER _____

FAMILY DOCTOR _____ CITY/STATE _____

REFERRED BY (DR/OTHER) _____

PRIMARY INSURANCE COVERAGE _____ ID# _____

GROUP# _____ INSURANCE EFFECTIVE DATE _____

NAME OF POLICY HOLDER _____ RELATIONSHIP _____

MAILING ADDRESS OF POLICY HOLDER _____

SS# OF POLICY HOLDER _____ BIRTHDATE OF POLICYHOLDER _____

POLICY HOLDER'S EMPLOYER _____

SECONDARY INSURANCE COVERAGE _____ ID# _____

GROUP# _____ INSURANCE EFFECTIVE DATE _____

NAME OF POLICY HOLDER _____ RELATIONSHIP _____

MAILING ADDRESS OF POLICYHOLDER _____

SS# OF POLICY HOLDER _____ BIRTHDATE OF POLICY HOLDER _____

POLICY HOLDER'S EMPLOYER _____

PLEASE READ AND SIGN BELOW

As a courtesy, we file claims to your insurance company. Your insurance coverage is a contract between you and your insurance company. You are responsible for the timely payment of your account.

•PATIENTS WITHOUT INSURANCE COVERAGE ARE EXPECTED TO PAY FOR SERVICES AFTER EACH VISIT.

•I hereby authorize payment directly to the Physician of surgical or medical benefits.

•I hereby authorize the Physicians of the Arkansas Foot & Ankle Clinic to release any information acquired in the course of my examination or treatment.

Sign (Patient or parent, if minor) Date _____

NAME _____ DATE _____

PLEASE CIRCLE ANY OF THE FOLLOWING ILLNESSES YOU HAVE OR HAVE HAD:

- | | | | |
|----------------|---|-----------------------------|------------------|
| Asthma | Diabetes _____insulin _____ pills
_____diet controlled | Arthritis | Thyroid Disorder |
| Ulcers | High Blood Pressure | Kidney Disorders | MVP |
| Ankle swelling | Poor Circulation | Liver Disorders (Hepatitis) | High Cholesterol |
| Heart Trouble | Lung Disorders | Rheumatic Fever | |
| Free Bleeding | Blood Clots | Stroke | |
| HIV | Anemia | Neurological Disease | |
| Gout | Cancer | | |

List any illnesses you have or have had that are not listed above: _____

List family history of illnesses: _____

List any surgery you have had and when (include any foot surgery): _____

List when and where you have received a blood transfusion: _____

Circle any implants you have (hip, knee, heart valve, screws, rods, pins) OTHERS: _____

PLEASE CIRCLE ANY MEDICATION YOU ARE ALLERGIC TO:

- | | | | |
|-----------------------------|------------|---------|---------------|
| Local Anesthetic (Novocain) | Darvon | Codeine | Sulfa Drugs |
| Demerol | Penicillin | Aspirin | Adhesive Tape |

Type of reaction _____

List any other medication you are allergic to that is not listed above and your reaction: _____

Weight _____ Height _____ Shoe size _____

Do you smoke? No: _____ Yes: _____ # packs per day _____

Do you drink alcohol? No: _____ Yes: _____ 1-2/week 1-2/day +2/day

LIST ALL CURRENT MEDICATIONS (name/dosage): _____

DESCRIBE YOUR FOOT/ANKLE PROBLEM: _____

Have you consulted a Doctor (when, where)? _____

How long has the problem existed? _____

How have you tried to relieve this problem? _____