Name:_____ **DOB:**_____ **Chart Number:** _____

Sex: ☐**M** ☐**F** **Marital Status:** ☐ **S**ingle ☐ Married ☐ Widowed ☐ Divorced **SS#:** _____

E-mail: _____ **Spouse/Partner Name**: _____

E-mail newsletters, reminders, statements, etc. **Emergency Name:**_____ **Phone:**_____

Address:_____ **City:**_____ **State:**_____ **Zip:**_____

Home #:_____ **Cell #:**_____ **Other #:** _____

Employer:_____ **Phone:** _____

Employer Address:_____ **City:**_____ **State:**_____ **Zip:** _____

Primary Insurance:_____ Are you the insured? ☐**Yes** ☐**No**

Insured Information

Subscriber Name:_____ Relationship to insured: ☐**Spouse** ☐ **Child** ☐**Self** ☐ **other**

Phone #:_____ Sex: ☐**Male** ☐**Female** DOB:____/___/___

Address: _____

Policy ID:_____ Group ID:_____ Employer: _____

Secondary Insurance:_____ Are you the insured? ☐**Yes** ☐**No**

Insured Information

Subscriber Name:_____ Relationship to insured: ☐**Spouse** ☐ **Child** ☐**Self** ☐ **Other**

Phone #:_____ Sex: ☐**Male** ☐**Female** DOB:____/___/___

Address: _____

Policy ID:_____ Group ID:_____ Employer: _____

How did you find out about our practice? ☐ Physician ☐ Internet ☐ Telephone book ☐ Family member ☐ Friend ☐ Other: _____

What is the reason for your visit today? _____

_____ **Result of accident or work injury?** ☐**Yes** ☐**No**

How long has this bothered you? 1 2 3 4 5 6 7 ☐ days ☐ weeks ☐ months ☐ years

What treatments have you tried & have they been effective? _____

_____

On a scale of 1-10 (1 being no pain and 10 being the worst) what is your level of pain?____/10

The pain quality is: ☐**burning** ☐**constant** ☐**dull** ☐**sharp** ☐**shooting** ☐**throbbing** ☐**tingling** **O**ther:_____

PLEASE READ AND SIGN

The above information is correct to the best of my knowledge. I understand that throughout my treatment, I am responsible for notifying the physician and/or medical staff of any and all updates to the information listed above.

Patient Signature: _____ Date: _____

History and Physical

Name:_____ **DOB:**_____ **Chart Number:** _____

Medical History:
☐ Alcoholism ☐ Blood disorders ☐ Circulation problems ☐ **Musculoskeletal** ☐ Breathing issues
☐ Liver ☐ Sleep apnea ☐ Gout ☐ Allergies ☐ Heart disease ☐ Asthma
☐ Heart murmur ☐ Stomach/bowel ☐ Depression ☐ **A**nxiety disorder ☐ **M**ental illness ☐ Kidney disease
☐ Blood clot ☐ High cholesterol ☐ High blood pressure ☐ **Cancer** ☐ Hepatitis
☐ Neuropathy *(specify)* _____ ☐ Thyroid disease *(specify)* _____ ☐ Diabetes (type 1, type 2)
☐ Arthritis *(specify)* _____ ☐ **o**ther (*specify)* _____ ☐ HIV ☐ CVA
Are you pregnant? ☐ Yes ☐ No **Are you nursing?** ☐ Yes ☐ No ☐ Skin disorders ☐ Stroke

Surgical History ☐None ☐**Appendectomy** ☐ **C-Section** ☐**Angioplasty** ☐**Bypass** ☐**Cataract**s ☐ Cholecystectomy
Have you ever had any surgical procedures on foot/ankle or anywhere else on your body? ☐Yes ☐No
If yes, please describe: _____
Do you have any artificial joints? ☐ Yes (where?_____) ☐ No Do you have an artificial heart valve? ☐Yes ☐No

Social History
Do you smoke? ☐Yes ☐No If yes how many packs per day? ☐1 ☐2 ☐3 ☐4 ☐5 For how long?
Do you drink alcohol? ☐Yes, everyday (5-7 days/week) ☐Yes, occasionally/socially ☐No/Rarely
Substance abuse: ☐Yes, I have a current substance abuse problem. Please specify: _____
☐Yes, I had a past substance abuse problem. Please specify: _____
☐ No, I have never had a substance abuse problem
What is your occupation?_____ Does it involve mostly ☐ standing or ☐ sitting
Do you exercise regularly? ☐ No, I do not exercise regularly ☐ Yes, I do the following regular exercise: _____
_____

Family History Is there any family history *(blood relative)* of: *(Please indicate family member)*

☐ Alzheimer's	_____	☐ Depression	_____
☐ Arthritis	_____	☐ Diabetes	_____
☐ Bleeding disorders	_____	☐ Emphysema	_____
☐ Blood clot	_____	☐ Heart disease	_____
☐ Cancer	_____	☐ High Blood Pressure	_____
☐ Cataracts	_____	☐ Neurological	_____
☐ Circulation problems	_____	☐ Strokes	_____
☐ Other (specify):	_____		

Review of Systems *(Please check the box if you currently have any of these symptoms or check "NONE")*

Cardiovascular	☐leg pain when walking	☐ fever	☐chest pain/pressure	☐leg swelling	☐cold hands/feet
	☐fainting	☐ palpitations	☐vascular disease	☐valve problems	☐**NONE**
Genitourinary	☐**blood in urine**	☐**hesitancy**	☐**incontinence**	☐increased urgency	
	☐**decreased frequency**	☐excessive urination	☐kidney disease	☐kidney stones	☐**NONE**
Gastrointestinal	☐abdominal pain	☐heartburn	☐blood in stool ☐vomiting	☐ulcers	☐constipation
	☐diarrhea	☐trouble swallowing	☐decrease appetite	☐increase appetite	☐**NONE**
Integumentary	☐athletes foot	☐nail abnormalities	☐keloids	☐itchiness	☐dry, scaly skin ☐**NONE**
Hematologic	☐lower leg ulcers	☐sickle cell disease	☐anemia	☐blood thinners	☐clotting disorders ☐**NONE**
Neurological	☐tingling	☐weakness	☐seizures	☐numbness	☐headaches
	☐tremors	☐paralysis			☐**NONE**
Musculoskeletal	☐back pain	☐joint swelling	☐muscle weakness	☐muscle pain	☐neck pain
	☐sciatica	☐joint stiffness	☐joint pain	☐joint instability	☐arthritis ☐**NONE**
Respiratory	☐chest pain	☐wheezing	☐COPD	☐coughing	☐snoring
	☐shortness of breath	☐emphysema			☐**NONE**

PLEASE READ AND SIGN
The above information is correct to the best of my knowledge. I understand that throughout my treatment, I am responsible for notifying the physician and/or medical staff of any and all updates to the information listed above.

Patient Signature: _____ Date: _____

Name: _____ **Chart #:**_____ **Date of birth:** _____

Ethnicity: ☐Hispanic or Latino ☐Not Hispanic or Latino ☐Declined to specify

Race: ☐Asian ☐American Indian or Alaska Native ☐Black or African American

☐White ☐Native Hawaiian or other Pacific Islander ☐Declined to specify

Preferred Language: _____ ☐Declined to specify

Pharmacy Name: _____ **Pharmacy Phone:** _____

Pharmacy Address: _____ City, State, Zip: _____

Primary Care Physician:_____ Phone:_____ Date Last Seen: _____

Address:_____

Referring Physician:_____ Phone:_____ Date Last Seen: _____

Address: _____

Privacy Information Preferences

Do you want to be exempt from public reporting? ☐Yes ☐No **Can we send mail to the address on file? ☐Yes ☐No**

Can we call the phone number on file? ☐Yes ☐No Can we leave voicemail on machine? ☐Yes ☐No

Will you allow us to send internet based (e-mail) delivery of re **minders and newsletters? ☐Yes ☐No**

If yes, please provide your e-mail address: _____

Who can we leave messages with? ☐Wife ☐Husband ☐Daughter ☐Son ☐Other:

Name(s):_____

Smoking Status

☐Current Every Day ☐Smoker, Current Status Unknown

☐Current Some Day ☐Heavy Tobacco ☐Unknown If Ever

☐Former ☐Never ☐Light Tobacco ☐I decline to answer

Vital Signs

Blood Pressure:_____/ _____

Height:_____ Weight: _____

Current Medications

☐No known Medications ☐I take the following medications

Name: _____

Name: _____

Name: _____

Name: _____

Name: _____

Name: _____

Name: _____

Use Back of this form if more room is needed

Allergies

☐No Known Allergies ☐ No Known Drug Allergies

Name: _____ Reaction:_____

Name: _____ Reaction:_____

Name: _____ Reaction:_____

Name: _____ Reaction:_____

Name: _____ Reaction:_____

Name: _____ Reaction:_____

Name: _____ Reaction:_____

Use back of this form if more room is needed

Date of Last Flu Shot _____ **Did you receive a pneumococcal vaccination? ☐Yes ☐ No**

Have you fallen in the last 12 months? ☐Yes ☐No How many times have you fallen? ____ Were you injured? ☐Yes ☐No

Have you completed any Advanced Directives? ☐Yes ☐ No

PLEASE READ AND SIGN: The information on my intake form(s) is correct to the best of my knowledge. I understand that throughout my treatment, I am responsible for notifying the physician and/or medical staff of any and all updates to the information listed above. *(Assignment of Benefits)*: I authorize payment of medical benefits to the practice named above. *(Release of Information)*: I authorize the release of any medical information necessary to process this claim. *(HIPAA Privacy)*: I acknowledge that I received my HIPAA Privacy Practices Notice. *(Medication History)*: I authorize the Doctor's office to retrieve my medication history.

Signature: _____ Date: _____

Associated Foot & Ankle Specialist, P. C.
1567 Milstead Road, Suite A • Conyers, GA 30012

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby give my consent for Associated Foot & Ankle Specialists, P.C. to use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). (Associated Foot & Ankle Specialists Notice of Privacy practices provides a more complete description of such uses and disclosures)

I have the right to review the Notice of Privacy Practices prior to signing this consent. Associated Foot & Ankle Specialists reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Associated Foot & Ankle Specialists Privacy officer at 1567 Milstead Road, Suite A Conyers, GA 30012.

With this consent, Associated Foot & Ankle Specialists may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory results among others.

However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form I am consenting to Associated Foot & Ankle Specialists use and disclosure of my personal health information to carry out treatment, payment and healthcare options.

I may revoke my consent in writing except to extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Associated Foot & Ankle Specialists may decline to provide treatment to me.

_____	_____
Signature	Date
_____	_____
Print Name	Witness