New Patient Information Form

Welcome!



SIGNATURE
FOOT & ANKLE

SIGNATURE FOOT & ANKLE

PATIENT INFORMATION FORM

Name

Date of Birth : / / Today's Date: / /

Age: Sex:

Height: Weight:

Shoe Size: Email:

Phone Number: Cell Phone:

Address:

City: State:

Zip:

Ethnicity/Race: Primary Language:

PRIMARY CARE PHYSICIAN

Primary Care Physician: Date Lasts Seen: / /

Doctor's Phone # Doctor's Fax #:

PHARMACY

Pharmacy Name: Phone #:

Address:

EMERGENCY CONTACT

Emergency Contact: Relationship:

Phone #:

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INSURANCE INFORMATION

Primary Insurance Company: _____ Insurance Phone #: _____

Insured Name: _____ DOB: __ __ / __ __ / __ __

Employer: _____ Policy Number: _____

Relationship: _____ Policy Holder Phone #: _____

Referral Needed?: ☐ Yes ☐ No

Secondary Insurance Company: _____ Insurance Phone #: _____

Insured Name: _____ DOB: __ __ / __ __ / __ __

Employer: _____ Policy Number: _____

Relationship: _____ Policy Holder Phone #: _____

Workers Comp? ☐ Yes ☐ No

PAST MEDICAL HISTORY (Please check all that apply)

- ☐ Glaucoma
- ☐ Dentures
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ COVID-19
- ☐ High Blood Pressure
- ☐ Rheumatic Fever
- ☐ Stroke
- ☐ Poor Circulation
- ☐ Asthma
- ☐ COPD/Emphysema
- ☐ Liver Disease
- ☐ Hepatitis: A B C
- ☐ Renal Disease
- ☐ Pacemaker/Stimulator
- ☐ Diabetes ____ years
  - ☐ Diet-Controlled
  - ☐ Oral Medication
  - ☐ Insulin Dependent
- ☐ Thyroid Disease
- ☐ Bleeding Disorder
- ☐ Sickle Cell Anemia
- ☐ HIV/AIDS
- ☐ Arthritis
- ☐ Bladder Disorder
- ☐ Bone/Joint Disorder
- ☐ Low Back Problems
- ☐ Gout
- ☐ Epilepsy/Seizures
- ☐ Neurological Condition
- ☐ History of Blood Clots
- ☐ Neuropathy
- ☐ Cancer _____
- ☐ Psychiatric Disorder
- ☐ Skin Disorder
- ☐ Keloid Formation
- ☐ Chemical Dependency
- ☐ Alcoholism
- ☐ Pregnancy # _____
- ☐ Births # _____
- ☐ Other: _____

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HISTORY OF CURRENT CONDITION

What specific problem brings you to our office today?

Where is the Pain/Problem Located? Please mark on picture(s) below.



LEFT FOOT



RIGHT FOOT

How long ago did this problem start? DAYS / WEEKS / MONTHS / YEARS

Is the condition a result of an injury? Yes No If yes, how did it occur:

Date of injury: / / Motor Vehicle Work Other:

Description of pain: (circle all that apply)
None Sharp Dull Aching Burning Radiating Itching Stabbing Numbness
Throbbing Worse in the AM Worse in the PM With first few steps out of bed/rest
Worse with walking/standing Other:

How would you rate your pain on a scale of 0 to 10?

(No pain) 0 1 2 3 4 5 6 7 8 9 10 (Worst Pain)

Have you experienced this problem in the past? Yes No

What makes your symptoms better? Worse?

What other treatments have you tried? Rest Ice/Heat Bracing/Arch Injections Physical Therapy Other:

Medications:

Have you seen another doctor for this problem? Yes No Who?

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MEDICATIONS (Please include any supplements and vitamins)

Current Medications (name, strength, dose):

1.
2.
3.
4.
5.
6.
7.
8.
9.
10.

ALLERGIES (Please also list any drug intolerances)

Allergies: Sulfa ☐ Latex ☐ Penicillin ☐ Codeine ☐ Lidocaine ☐ Other:

Please specify the type of reaction to the above allergen(s):

☐ No Known Allergies

PAST SURGICAL HISTORY / HOSPITALIZATIONS

☐ None

Prior Foot / Ankle Surgery ☐ Yes, procedure:

Prior Vascular Surgery ☐ Yes, procedure:

Prior Cardiac Surgery ☐ Yes, procedure:

Procedure/Hospitalization	Year

Have you had any complications with anesthesia in the past? ☐ No ☐ Yes, what type?

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FAMILY HISTORY (Check all that apply and circle involved family members)

DISEASE	FAMILY MEMBER	DISEASE	FAMILY MEMBER
Heart Disease	Mother / Father / Sibling / Child	Stroke	Mother / Father / Sibling / Child
High Blood Pressure	Mother / Father / Sibling / Child	Thyroid Disease	Mother / Father / Sibling / Child
Rheumatoid Arthritis	Mother / Father / Sibling / Child	Blood Clots	Mother / Father / Sibling / Child
Diabetes	Mother / Father / Sibling / Child	Kidney Disease	Mother / Father / Sibling / Child
Cancer/Tumor	Mother / Father / Sibling / Child	Other:	Mother / Father / Sibling / Child

SOCIAL HISTORY

Occupation: Physical Demands at work:

What type of shoes do you typically wear?

Martial Status ☐ Single ☐ Married ☐ Widowed ☐ Partnered ☐ Separated ☐ Divorced

Do you smoke? ☐ Yes ☐ No If yes, how many packs per day? For how long?

☐ Quit – How long ago?

Do you drink? ☐ Yes ☐ No If yes, how often? Rarely Occasionally Moderately Daily

Use of Recreational Drugs? ☐ Yes ☐ No

Date of your last physical examination? ☐☐ / ☐☐ / ☐☐ Physician:

Highest level of education: ☐ High School ☐ College ☐ Masters ☐ Doctorate

Do others depend on you for their care? ☐ Children ☐ Pets ☐ Elderly/Disabled Family

Exercise: ☐ Never ☐ Rarely ☐ Occasional ☐ Weekly ☐ Several x/weeks ☐ Daily

Are you pregnant: ☐ Yes ☐ No Are you Claustrophobic: ☐ Yes ☐ No

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REVIEW OF SYMPTOMS (These are symptoms you are currently experiencing)

GENERAL

- [ ] Fatigue
- [ ] Fever
- [ ] Weight Loss > 10

RESPIRATORY

- [ ] Chronic Cough
- [ ] Decreased Exercise Tolerance
- [ ] Difficulty Breathing
- [ ] Coughing Up Blood
- [ ] Sputum Production
- [ ] Wheezing

GENITOURINARY

- [ ] Vaginal Discharge
- [ ] Painful Urination
- [ ] Change in Urinary Stream
- [ ] Increased Frequency
- [ ] Blood in Urine
- [ ] Loss of Bladder Control
- [ ] Urinary Retention

NEUROLOGICAL

- [ ] Dizziness / Vertigo
- [ ] Headaches
- [ ] Numbness / Tingling
- [ ] Passing Out
- [ ] Seizures
- [ ] Tremor

SKIN

- [ ] Nail Changes
- [ ] New Lesions / Ulcers
- [ ] Frequent Rashes
- [ ] Skin Color Changes

CARDIOVASCULAR

- [ ] Chest Pain
- [ ] Leg Pains with walking
- [ ] Leg Swelling
- [ ] Night Awakening due to trouble Breathing
- [ ] Palpitations
- [ ] Shortness of Breath

MUSCULOSKELETAL

- [ ] Decreased Motion
- [ ] Joint Pain
- [ ] Joint Redness
- [ ] Joint Swelling
- [ ] Joint Stiffness
- [ ] Muscle Wasting
- [ ] Muscle Weakness
- [ ] Muscle Aches / Pains

PSYCHIATRIC

- [ ] Anxiety / Depression
- [ ] Change in Sleep Pattern
- [ ] Hallucinations
- [ ] Suicidal Thoughts

ENT

- [ ] Double Vision
- [ ] Loss of Vision
- [ ] Decreased Hearing
- [ ] Earache
- [ ] Nose Bleeds
- [ ] Dry Mouth
- [ ] Hoarseness
- [ ] Sore Throat

GASTROINTESTINAL

- [ ] Abdominal Pain
- [ ] Change in Bowel Habits
- [ ] Constipation
- [ ] Diarrhea
- [ ] Nausea
- [ ] Vomiting
- [ ] Heartburn / Ulcers

VASCULAR

- [ ] Intermittent Claudication
- [ ] Leg Cramps
- [ ] Varicose Veins

ENDOCRINE

- [ ] Appetite Changes
- [ ] Cold Intolerance
- [ ] Increased Thirst
- [ ] Increased Urination
- [ ] Hair Changes
- [ ] Sexual Dysfunction

NECK

- [ ] Neck Pain
- [ ] Swollen Glands

HEMATOLOGY

- [ ] Easy Bruising
- [ ] Prolonged Bleeding

PATIENT ASSESSMENT

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The physicians at Signature Foot & Ankle are concerned about your overall health and wellbeing and are evaluating factors in which may impact your overall health and orthopedic health. The following questions are intended to give the physicians information about your general health.

1. **Have you been fully vaccinated for COVID-19** ☐ **Yes** ☐ **No**
2. **Have you had a bone density study (DEXA scan) for osteoporosis at least once since 60?** ☐ **Yes** ☐ **No** ☐ **N/A**

   If yes, in what year did you have your most recent DEXA? _____
3. **Have you been on medicine to treat osteoporosis?** ☐ **Yes** ☐ **No**

   If yes, has it been prescribed within 12 months? ☐ **Yes** ☐ **No**

   What medication are you taking? _____
4. **Do you take Calcium?** ☐ **Yes** ☐ **No**
5. **Do you take Vitamin D?** ☐ **Yes** ☐ **No**
6. **Have you fallen more than twice or fallen and hurt yourself in the past year?** ☐ **Yes** ☐ **No**
7. **Have you had the influenza vaccine for the current flu season?** ☐ **Yes** ☐ **No**
8. **Have you had the pneumococcal vaccine?** ☐ **Yes** ☐ **No**
9. **Do you have an Advanced Care Plan?** ☐ **Yes** ☐ **No**

REFERRAL SOURCE

How did you hear about our practice?

Doctor Referral **Internet Research** **Friend/Family** **Workers Comp** **Urgent Care / Hospital** **Mailer / Flyer**
Our Website **Insurance Referral** **Other**

More Detail (Doctor / Friend / Hospital Name, Other Source) _____

SIGNATURE OF PATIENT/GUARDIAN

To the best of my knowledge, I have answered the questions on this form accurately. I understand that providing incorrect or incomplete 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.

_____ _____

Printed Name of Patient, Parent or Guardian* **Signature**

_____ _____

If other than Patient, relationship to Patient **Date**

*Parent or legal guardian name and signature required for individuals under age 18

SIGNATURE FOOT & ANKLE

PHOTO AND PROMOTIONAL RELEASE FORM

I understand that photographs, videotapes, digital, or other images may be recorded to document my care, and I consent to this. I understand that Signature Foot and Ankle will retain ownership rights to these photographs, videotapes, digital, or other images, but that I will be allowed access to view them or obtain copies. I understand that these images will be stored in a secure manner that will protect my privacy and that they will be kept for the time period required by law or outlined in Signature Foot and Ankle's policy. Images that identify me will be released and/or used outside the institution only upon written authorization from me or my legal representative.

I give my consent to have photographs, videotaped images, or other images made during the visit. I understand and agree that these images may be used by Signature Foot and Ankle for the purpose outlined below. They will not include any identifiable features when used outside of my chart. This includes, but is not limited to: Teaching purposes, which includes being shown to other patients, residency, and research. Advertisements for Signature Foot & Ankle.

Signature of Patient/Legal Representative	**If legal representative, relationship to Patient**	**Date**

SIGNATURE FOOT & ANKLE

CONSENT TO USE AND DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT, PAYMENT, OR HEALTHCARE OPERATIONS

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

May we discuss your medical condition with any member of your family? ☐ **Yes** ☐ **No**

If YES, please name the members allowed:

_____

_____

_____

This consent was signed by: _____ **(Print Name Please)**

_____ _____

Signature: **Date**

_____ _____

Witness: **Date**