Ankle and Foot Associates PC Patient Information

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*****Please fill out each form in its entirety- All information is important for treatment and for your insurance coverage*****

Patient Name: _____ DOB_____/____/_____ SSN: _____-_____-_____

Sex: (*Circle*) M F Marital Status: Single___ Married___ Divorced___ Widowed___ Other___

Address: _____City:_____State:_____Zip:_____

Primary Phone: (_____) _____-_____ Cell Phone: (_____) _____-_____

Work: (_____) _____-_____ Okay to leave a message: Yes_____ No_____

Race: American Indian___ Alaska Native___ Asian___ Black/African American___ Hawaiian/Pacific Islander___

White___ Other: __ Prefer to not answer: ___ **Ethnicity:** Hispanic/Latino__ Not Hispanic/Latino___ Other:___

Primary Language: Arabic ___ Somali ___ English___ Spanish___ French___Other: __

Responsible Party Information

Please fill in this section out if someone other than the patient is responsible for paying any balance due to AFA PC. This is to whom any statements will be mailed to. **This section must be filled out if the patient is a minor.**

Name: _____ DOB: ____/___/_____ SSN: _____-_____-_____
Phone: (_____) _____-_____ Relationship to Patient: _____
Billing Address: _____ City: _____ State: _____ Zip: _____

Patient HIPPA ACKNOWLEDGMENT AND DESIGNATION DISCLOSURE FORM

Acknowledgement of Practice's Notice of Privacy Practice's:

By subscribing my name below, I acknowledge that I was provided a copy of the Notice of Privacy Practices (NPP) and that I have read (or had the opportunity to read if I so choose) and understands the Notice of Privacy Practices (NPP) agree to its terms.

Designation of certain relatives, Close Friends and other Caregivers as my Personal Representative:

I agree that the practice may disclose certain pieces of my health information to a Personal representative of my choosing, since such person is involved with my healthcare or payments relating to my healthcare. In that case, the Physician Practice will disclose only information that is directly relevant to the person's involvement with my healthcare or payments relating to my healthcare.

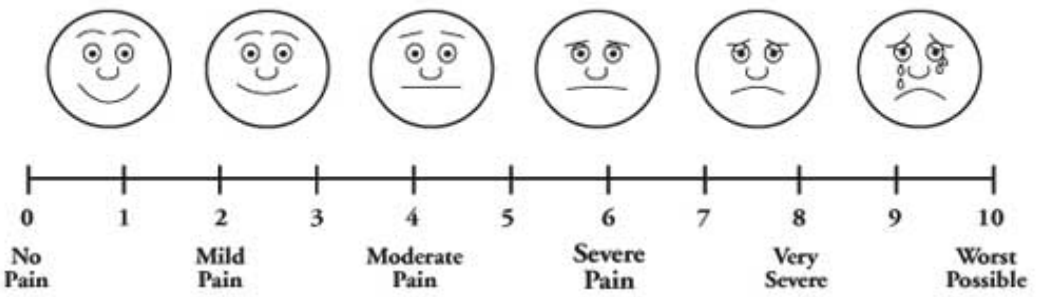
Emergency Contact Name: _____ Relationship: _____
Phone: (_____) _____- _____ Secondary Phone: (_____) _____-_____

ATTEST

I do hereby attest that this information is true, accurate, and complete to the best of my knowledge. I understand that falsification, omission, or concealment of any material fact may subject me to all fees for service and/or other liability. I also understand that I am to notify Ankle and Foot Associates PC immediately of any changes to the above information and annually upon the office's request. Understanding all of the above, I hereby provide informed consent to Ankle and Foot Associates PC to enroll me in the ePrescribe program. I have had the chance to ask questions and all of my questions have been answered to my satisfaction.

Signature:_____ DATE: _____/ _____/ _____

HOW MUCH DOES IT HURT?



What are we seeing you for:

_____

_____

***Medications List;** _____

Please see attached list Y N

***My area of pain is in or around:** Not Applicable_____ No Pain____

***Right Foot**: Ankle____ Arch ____ Heel____ Ball____ Achilles Tendon (heel cord) ____

Toes 1 2 3 4 5 **Toenail(s)** 1 2 3 4 5

***Left Foot:** Ankle____ Arch____ Heel____ Ball____ Achilles Tendon (heel cord) _____

Toes 1 2 3 4 5 **Toenail(s)** 1 2 3 4 5

Primary Care Physician: _____ Date of last visit : _____

Name of Pharmacy: _____ Address: _____

Height: _____ Weight: _____ Shoe Size: _____

***I would describe my pain as:** No Pain____ Dull____ Sharp____ Throb____ Burn____ Numb____ Tingling____ Shooting_____ Deep____ Other____

***Do you remember any trauma or incident which may have caused this?** Unsure____ No____Yes:____

ALLERGIES:_____

__Penicillin	__Iodine	__Local Anesthetic	__Adhesives (tape)	__Sulfa drugs
__Betadine	__Morphine	__Vaccines	__Latex	__Benadryl
__Cephalosporin's	__Aspirin	__Ibuprofen	__Naprosyn	__Bacitracin
__Mycins	__Neosporin	__Codeine	__Other	

Food Allergies: _____

Environmental Allergies: _____

Have you ever had an anaphylactic reaction? YES NO Do you carry an Epi-pen? YES NO

SOCIAL HISTORY:

Tobacco: __Never smoker __Former smoker __Current smoker __Smokeless Tobacco

How long have you smoked/used tobacco? ____years; ____months; When did you quit:_____

How many packs per day do/did you smoke? _____

Alcohol: __Never drink alcohol __Currently drink alcohol __No longer drink alcohol

How many alcoholic drinks per: _____day; _____week; _____month; _____year

Illicit/Recreational Drug Use: __Never used ___Currently use ___No longer use ___ Methadone

What drugs have you used? ___Marijuana; ___Cocaine; ____Heroin; ___Pain Meds; ___Other

Have you ever taken drugs via syringe or IV (intravenously)? YES NO

Are you a Diabetic Patient? Type1 ____ Type2 _____ None_____ **Name of Endocrinologist**:_____

Do you bruise easily? Yes____ No____ **Clotting Problems?** Yes___ No ____ **Scar Poorly?** Yes____ No____

Sickle Cell Disease/trait? Yes___ No____ **Any adverse reactions to Anesthesia or Medications?** Yes____ No____Unknown___

FAMILY HISTORY

Mother	Yes	No	Cancer	Yes	No	Diabetes	Yes	No	Heart Disease
Father	Yes	**No**	**Cancer**	**Yes**	**No**	**Diabetes**	**Yes**	**No**	**Heart Disease**

SURGICAL HISTORY

Diagnosis	Yes	No	Diagnosis	Yes	No	Diagnosis	Yes	No
Achilles Tendon Release			Arterial bypass			Foot Surgery		
Amputation			Bunionectomy			Hammer toe repair		
Ankle fracture surgery			Foot fracture surgery			Toenail removal		
Heart surgery			Pacemaker			Spleen		
Joint replacement			Vascular			Knee/Hip		
Cancer			Gallbladder surgery			Appendix		

MEDICAL HISTORY

Medical History	Y	N
Blood Clots	Y	N
Diabetes I. II.	Y	N
Circulation Problems	Y	N
Heart Disease	Y	N
Liver Disease	Y	N
Rheumatoid Arthritis	Y	N
MRSA	Y	N
Stroke	Y	N
Arthritis	Y	N
Kidney Infection	Y	N
Bleeding Disorder	Y	N
Heart Attack	Y	N
Pain in Legs/Feet	Y	N
Stomach Ulcers	Y	N

Medical History	Y	N
Acid Reflux (GERD)	Y	N
Callus Formation	Y	N
Fibromyalgia	Y	N
Congestive Heart Failure	Y	N
Hepatitis: _____		
Lung Problems	Y	N
Neurological Disorder	Y	N
RSD/CRPS	Y	N
Swelling legs/feet	Y	N
Cholesterol	Y	N
Neuropathy	Y	N
Chemotherapy	Y	N
Kidney Stones	Y	N
Sports Related Injury	Y	N

Medical History	Y	N
Anxiety	Y	N
Cancer	Y	N
Foot Ulceration	Y	N
Currently Breast Feeding	Y	N
High Blood Pressure	Y	N
Lupus	Y	N
Osteoporosis	Y	N
Seizure Disorders	Y	N
Thyroid Disorders	Y	N
Gout	Y	N
Osteopenia	Y	N
Mitral Valve Prolapse	Y	N
Depression	Y	N
Other: _____		

CURRENT SYMPTOMS

General	Y	N
Weight Change	Y	N
Chills	Y	N
Sleep Disorder	Y	N
Other:_____		

Skin	Y	N
Rash/Hives	Y	N
Mole Changes	Y	N
Skin Cancers	Y	N
Thick Nails	Y	N
Other:_____		

Eyes	Y	N
Double Vis/	Y	N
Cataracts	Y	N
Glaucoma	Y	N
Glasses/Contacts	Y	N
Other:_____		

Kidneys	Y	N
Prostate Problems	Y	N
Pain with Urination	Y	N
Night time Urination	Y	N
Other:_____		

Ears/Nose/Throat	Y	N
Hearing Problems	Y	N
Balance Problems	Y	N
Smell Disorder	Y	N
Sore Throat	Y	N
Other:_____		

Lungs	Y	N
Pain with Breathing	Y	N
Shortness of Breath	Y	N
Asthma/Emphysema	Y	N
Persistent Cough	Y	N
Other:_____		

CURRENT SYMPTOMS

Cardiovascular	Y	N
High Blood Pressure	Y	N
Heart Valve Problems	Y	N
Chest Pain	Y	N
Irregular Beat	Y	N
Other: _____		

Stomach	Y	N
Ulcer/GERD	Y	N
Abdominal Pain	Y	N
Nausea/Vomit	Y	N
Heart Burn	Y	N
Other:_____		

Circulation	Y	N
Leg Cramps walking	Y	N
Cramps in bed	Y	N
Blood Clots	Y	N
Vein Problems	Y	N
Other: _____		

CURRENT SYMPTOMS

Blood/Lymph	Y	N
Clotting Problems	Y	N
Bruise Easy	Y	N
Swollen Glands	Y	N
Transfusion	Y	N
Other:_____		

Nerves	Y	N
Seizures/Strokes	Y	N
Mini Strokes	Y	N
Numbness/Tingling	Y	N
Dizzy Spells	Y	N
Other:_____		

Musculoskeletal	Y	N
Bone Pain	Y	N
Joint Pain	Y	N
Sprain/Strain	Y	N
Other: _____		

Psychologic	Y	N
Anxious/Depressed	Y	N
BiPolar/Obs.comp	Y	N
Other:_____		

Endocrinology	Y	N
High Blood Pressure	Y	N
Diabetes	Y	N
type 1___ type2___		

Are You Currently Pregnant
Y N

ePrescribing & Patient Portal Consent Form

Here at Ankle and Foot Associates we are utilization two new electronic options available to our practice, and our patients. ePrescribing and Patient Portal. The first is ePrescribing, ePrescribing is defined as a physician's ability to electronically send an accurate, error free and understandable prescription directly to a pharmacy from the point of care. Congress has determined that the ability to electronically send prescriptions is an important element in improving the quality of patient care. ePrescribing greatly reduces medication errors and enhances **patient safety.** Next is our Patient portal, Federal guidelines mandate that patients have immediate access to their medical records via the internet. Ankle and Foot Associates PC offers a secure viewing and communications service to patients to view parts of their records and communicate with our staff and physicians.

Prescription Monitoring Program

NOTIFICATION: Ankle and Foot Associates PC participates in a Prescription Monitoring Program (PMP) which is a system in which controlled prescription drug data is collected in a database, centralized by each state, and administered by an authorized state agency to promote the appropriate use of controlled substances for legitimate medical purposes, while deterring the misuse, abuse, and diversion of controlled substances

PRESCRIPTION REFILLS POLICES REMINDER

1. Only one pharmacy may be used for filling prescriptions. You should notify us if you change pharmacies.
2. Contact you r plan regarding your drug coverage.
3. Refills are completed via a pharmacy request.
4. Because most physicians are only in clinic 3-4 days per week, prescriptions refills may take 3-5 business days to process.
5. Take your medication exactly as instructed by provider. Never change the dosage or frequency your medication without instructions from your physician. Refill requests will not be approved if you "run out early". You are responsible for keeping your prescriptions and medications safely in your care. Lost or stolen medications or prescriptions will not be replaced until it is time for your next refill. Exceptions may be made if you have a police report, but only at the discretion of your doctor.
6. You may be required to see your physician for a follow-up visit prior to obtaining a medication refill.
7. No Refills Past 12Pm Friday to 8Am Mondays. Any refill requests ordered on Friday will not be available to pick up, or ePrescribe until the following Monday, or business day providing holidays.
8. **Control substances will only be prescribed for post-surgical pain control and in the event of severe injury (fracture etc.) the decision will be made at the discretion of your physician. After initial prescription any additional request for controlled substances ie pain medication, will only be provided after thorough assessment by your physician, and requests will not be taken over the phone. If you feel that it is an emergent situation at the time of your request, and your physician is unavailable, you will be instructed to go to your local emergency department for an evaluation.**

ePrescribe and Patient Portal Acknowledgment and Agreement: By signing this consent form you are agreeing that Ankle and Foot Associates PC can request and use your prescription medication history from other healthcare providers and/or third party pharmacy benefit payers for treatment purposes. Understanding all of the above, I hereby provide informed consent to Ankle and Foot Associates PC to enroll me in the ePrescribe Program. I have had the chance to ask questions and all of my questions have been answered to my satisfaction. **The Undersigned certifies that He/She has read, Understand and accepts the terms and has had the opportunity to receive a copy for their records.** I understand the risks associated with online communications between my physician and me, and consent to the conditions outlined herein. In addition, I agree to follow the instructions set forth herein, including the Policies and Procedures set forth in the log in screen, as well as any other instructions that my physician my imposes to communicate with patients via online communications. I understand and agree with the information that I have been provided. – You may decline acceptance of patient portal- to decline **DO NOT** provide your email address**. Signature is still required to ensure that we have provided you the option of participating in our patient portal.**

Email Address: _____ Date: _____

Signature of Patient or Representative: _____ DOB: _____