WELCOME TO SHORE FOOT & ANKLE

Patient Information Sheet

All of your personal and medical information will remain confidential as required by HIPAA privacy regulations.

Last Name:_____ First Name:_____ Middle: _____

Home Address:_____

City/State/Zip:_____

Home Phone:_____ Work:_____ Cell: _____

E-Mail:_____

Social Security Number:_____ Sex (M/F): _____ Date of Birth:_____

Marital Status: Single / Married / Widow(er) / Divorced / Separated Employer: _____

Spouse's Name:_____ Spouse's Date of Birth: _____

Spouse's Employer: _____ Spouse's Work Phone: _____

Nearest Friend or Relative to Notify in an Emergency - other than spouse:

_____ Phone Number: _____

Race:(Caucasian, Black/African American, Hispanic, Asian, Pacific Islander/Hawaiian, Native American Indian, Alaskan Native, Black/Latino, Arab, Asian Indian, Middle Eastern, Other)

Primary Language: _____ U.S. Citizen: Yes or No

Primary Care Physician:_____

Phone: _____ Fax: _____

Address: _____ Date of Last Exam: _____

_____

Referred by: How did you hear about us?: _____

Name of Pharmacy: _____ City: _____ Phone:_____

INSURANCE INFORMATION

(Please present valid insurance cards and picture ID)

Primary Insurance Company Name:_____

Secondary Insurance Company Name: _____

If a dependent please complete below: _____

Responsible Party/Health Insurance Holder's Name:_____

Policy Holder's Date of Birth:_____ Social Security Number: _____

Address:_____ Phone: _____

Employer:_____ Work Phone:_____

If A Workers Compensation Claim - Please Give Claim Authorization Number Prior to Treatment

(Please complete other side of page)

PATIENT INFORMATION QUESTIONNAIRE

All of your personal and medical information will remain confidential as required by HIPAA privacy regulations.

DATE: _____ NAME: _____

Welcome to Shore Foot & Ankle. Please answer the following questions in order to get a detailed medical history and description of your problem.

What problems are you currently having? _____

_____

When did the problem begin? What was the date of the injury? _____

Rate the pain level 1 to 10 (10 = worst) _____

Describe the pain or problem _____

_____

When does it occur? What makes it better/worse? _____

_____

What treatments have you had for your problem? _____

_____

Past Medical History (please check all that apply):

( ) Acid Reflux
( ) Alcohol/Substance Abuse
( ) Anemia
( ) Arthritis (Location): _____
( ) Artificial Joints (Location): _____
( ) Asthma
( ) Back Problems
( ) Bladder/Urinary Problems
( ) Bleeding Disorders
( ) Blood Clots
( ) Bronchitis
( ) Cancer (Type):
( ) Cataracts
( ) Congestive Heart
( ) COPD
( ) Diabetes
( ) GI Bleeding
( ) Glaucoma
( ) Gout
( ) Heart Problems/Attack
( ) Heart Valve/Pacemaker
( ) Hepatitis (Type): _____
( ) High Blood Pressure
( ) High Cholesterol
( ) Kidney Disease/Stones
( ) Tick Bites
( ) Leg Swelling
( ) Liver Disease
( ) Neurological Disorders
( ) Neuropathy
( ) Osteporosis
( ) Pinched Nerves
( ) Prostate Problems
( ) Poor Circulation
( ) Raynaud's Disease
( ) Restless Legs
( ) Seizures
( ) Sickle Cell
( ) Stroke/TIA
( ) Lymes Disease

Muscle Weakness:
( ) Left ( ) Right
( ) Thyroid Disease
( ) Vision Problems

Sexually Transmitted Disease:
( ) HIV
( ) Syphillis
( ) Herpes
( ) Other: _____

Psychological Disorders:
( ) ADHD
( ) Anxiety
( ) Depression
( ) Bipolar
( ) Anxiety
( ) Other: _____

Skin Problems:
( ) Eczema
( ) Psoriasis
( ) Other: _____

Other Health Ailments (not listed): _____

Female Patients: Are you pregnant? Yes / No Are you trying to get pregnant? Yes / No

Current Medications (Include all non-prescription, over-the-counter, vitamins and supplements): ❑ See my List

_____ _____ _____

_____ _____ _____

_____ _____ _____

NAME: _____

PATIENT INFORMATION QUESTIONNAIRE

Allergies (Check all that apply and describe the reaction you had):

( ) Adhesive Tape
( ) Aspirin
( ) Augmentin
( ) Bee Sting
( ) Ciprofloxacin
( ) Codeine
( ) Doxycycline
( ) Erythromycin
( ) Iodine/Betadine
( ) IVP Dye
( ) Keflex
( ) Latex
( ) Motrin/Advil
( ) Novocaine
( ) Oxycodone
( ) Penicillin
( ) Seafood
( ) Sulfa
( ) Tetanus
( ) Tetracycline

( ) **No Known Drug Allergies**
( ) Food: _____
( ) Other: _____
( ) Environmental: _____

Reaction: _____

Past Surgical History (Describe any and all surgical procedures on your body):

_____ _____ _____

_____ _____ _____

Have you ever had a bad reaction or allergic reaction to anesthesia? Yes / No (Describe):

_____

Have you or a family member been diagnosed with malignant hyperthermia or other abnormal reaction to anesthesia? Yes / No

Social History

Education Level / Work Training Completed: _____

Current Job Description: _____

Do you smoke tobacco products? Yes No Occasionally Rarely # per Day ____ Quit ____ years ago

Do you drink alcohol? Yes No Occasionally Rarely # per Day____ Quit ____ years ago

Do you use recreational drugs? No Yes, Type _____ Daily Rarely Occasionally Quit____ years ago

Medical marijuana? Yes No

Shoe Size: _____ Weight: _____ Height: _____ Last Blood Pressure Reading:_____

If Diabetic: Last Hgb Alc test _____ If HIV: Last CD4 # _____ , Viral load # _____

Family History Please list any family history of problems: including diabetes, stroke, heart problems, arthritic conditions or vascular problems as it may help diagnose a problem related to your health issues.

Mother - ( ) Alive ( ) Deceased Age____ Medical Problems:_____

_____

Father - ( ) Alive ( ) Deceased Age ____ Medical Problems:_____

_____

Other Family Members Medical Problems: _____

_____

(Please complete other side of page)

NAME: _____

REVIEW OF SYSTEMS

Please indicate if you are currently suffering from any of these problems on TODAY'S visit. (Check all that apply.)

General
( ) Fever
( ) Chills
( ) Night Sweats
( ) Trouble Sleeping
( ) Loss of Appetite
( ) Weight Loss
( ) Weight Gain

Head/Eyes
( ) Dizziness
( ) Headache
( ) Use of Glasses
( ) Loss of Vision
( ) Blurry Vision

Ear, Nose, Throat
( ) Loss of Hearing
( ) Hearing Aid
( ) Ringing in Ears
( ) Nose Bleeds
( ) Sinusitis
( ) Sore Throat
( ) Swollen Glands

Respiratory
( ) Asthma/Wheezing
( ) Difficulty Breathing
( ) Shortness of Breath
( ) Coughing

Cardiac
( ) Chest Pain
( ) Palpitations
( ) Chest Pressure

Gastrointestinal
( ) Trouble Swallowing
( ) Nausea/Vomiting
( ) Acid Reflux
( ) GI Ulcer
( ) Abdominal Pain
( ) Constipation
( ) Diarrhea
( ) Rectal Bleeding

Genitourinary
( ) Urinary Tract Infection
( ) Burning
( ) Blood
( ) Pain
( ) Frequency
( ) Incontinency
( ) Testicular Pain
( ) Irregular Periods
( ) Abnormal Discharge

Musculoskeletal
( ) Joint Swelling
( ) Back/Neck Pain
( ) Hip/Thigh/Knee Pain
( ) Joint Stiffness
( ) Bone or Joint Infection
( ) Calf Pain
( ) Leg Cramping when walking
( ) Tendonitis
( ) Dislocations

Neurological
( ) Fainting
( ) Seizures
( ) Numbness
( ) Tingling
( ) Abnormal Sensations
( ) Tremors
( ) Muscle Weakness
( ) Muscle Paralysis
( ) Weakness from Stroke

Dermatological
( ) Rashes
( ) Ulcers
( ) Sores
( ) Infection
( ) Abnormal Discoloration
( ) Peeling Skin

Psychological
( ) Nervousness
( ) Depression
( ) Bipolar
( ) Anxiety
( ) Memory Loss
( ) Confusion
( ) Insomnia
( ) ADHD

Lymphatic
( ) Leg Swelling
( ) Swollen Nodes
( ) Red Streaking (Angitis)

☐ No Problems Today

The above referenced ROS was reviewed with the patient: _____

Statement of Fact / Consent to Treatment: I have completed this form fully and to the best of my knowledge. I understand that it is my responsibility to inform the doctor with regards to any changes in medical history, medications, and medical insurance coverage prior to any follow up visits. I hereby consent to evaluation and medical treatment of current condition. Treatment may include physical examination, biopsy/tissue samples, x-ray exposure, and the use of sharp instrumentation to help diagnose and treat my current problem.

Signature: _____ Date: _____

NAME: _____

INSURANCE CERTIFICATION AND ASSIGNMENT

I certify that I am the person so indicated on the insurance card or the duly authorized agent of the patient authorized to furnish the information requested. I hereby request and assign all medical and surgical benefits to which I am entitled including Medicare, Medigap carrier, private insurance, HMO, PPO, worker's compensation, and any and all other health insurance plans be made directly payable to Dr. David Gannon and Shore Foot & Ankle for any services and medical supplies furnished to me by this office. I understand that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payments. I understand that even though I have some type of health care insurance that I am ultimately responsible for payments for services and supplies rendered by Dr. David Gannon and Shore Foot & Ankle. I understand that I am subject to the coverage and benefits of my health insurance at the time of service. I have provided my health insurance information so that Dr. David Gannon and Shore Foot & Ankle may bill my insurance for services rendered to me. I understand that I am subject to the coverage benefits of my health insurance program and may not be covered for all services under my plan. I understand that if my insurance requires a referral and/or authorization for services that it is my responsibility and the responsibility of my primary care doctor to obtain the referrals and proper authorizations before the time of my appointment. Under ERISA/Federal Law, in the event that my insurance plan refuses payment for medically reasonable and necessary services provided, I assign my ERISA rights to Dr. David Gannon and Shore Foot & Ankle for a full and fair review of any and all denied claims. I assign the payment of all benefits and penalties to Dr. David Gannon and Shore Foot & Ankle. I understand that I am financially responsible for any and all co-payments, non-covered care, deductibles, and balances for services rendered. I understand a 1.5 % interest charge will be added to any unpaid patient responsibility balance over 120 days. I understand that I am responsible for the payment of any collection fees incurred by Shore Foot and Ankle and Dr. David Gannon if my account goes unpaid and is sent to a debt collection service. I consent to release all information necessary by Dr. David Gannon and Shore Foot & Ankle for resolution of unpaid service disputes in compliance with HIPAA privacy procedures. I have had an opportunity to review the Shore Foot and Ankle Financial Policy Statement.

Signature: _____ Date: _____

(Please complete other side of page)

NAME: _____

SHORE FOOT & ANKLE

SUMMARY OF NOTICE OF PRIVACY PRACTICES

This summary is provided to assist you in understanding the attached Notice of Privacy Practices

The attached Notice of Privacy Practices contains a detailed description of how our office will protect your health information, your rights as a patient and our common practices in dealing with patient health information. Please refer to that Notice for further information.

Uses and Disclosures of Health Information.

We will use and disclose your health information in order to treat you or to assist other health care providers in treating you. We will also use and disclose your health information in order to obtain payment for our services or to allow insurance companies to process insurance claims for services rendered to you by us or other health care providers. Finally, we may disclose your health information for certain limited operational activities such as quality assessment, licensing, accreditation and training of students.

Uses and Disclosures Based on Your Authorization.

Except as stated in more detail in the Notice of Privacy Practices, we will not use or disclose your health information without your written authorization.

Uses and Disclosures Not Requiring Your Authorization.

In the following circumstances, we may disclose your health information without your written authorization:

- To family members or close friends who are involved in your health care;
- For certain limited research purposes;
- For purposes of public health and safety;
- To Government agencies for purposes of their audits, investigations and other oversight activities;
- To government authorities to prevent child abuse or domestic violence;
- To the FDA to report product defects or incidents;
- To law enforcement authorities to protect public safety or to assist in apprehending criminal offenders;
- When required by court orders, search warrants, subpoenas and as otherwise required by law.

Patient Rights. As our patient, you have the following rights:

- To have access to and/or a copy of your health information;
- To receive an accounting of certain disclosures we have made of your health information;
- To request restrictions as to how your health information is used or disclosed;
- To request that we communicate with you in confidence;
- To request that we amend your health information;
- To receive notice of our privacy practices.

If you have a question, concern or complaint regarding our privacy practices, please refer to the attached Notice of Privacy Practices for the person or persons whom you may contact.

I certify that I am allowing disclosure of my health care information to _____ Relationship to patient _____

Acknowledgment of Receipt of Notice of Privacy Practices:

I acknowledge that I was provided an opportunity to review a copy of the Notice of Privacy Practices and understand the meaning of its contents. I understand that I can request a copy of a summary of the privacy practices, a full printed copy of the Notice of Privacy Practices, or may review the privacy practices on the website at www.shorefootandankle.com

Signature: _____ Date: _____