Foot & Ankle RECONSTRUCTION OF NORTH GEORGIA

(770) 999-0804
www.footandanklereconstructionga.com

Patient Information

First Name: M.I.: Last Name:

How would you like to be called: SS#: Sex: M / F

Age: DOB: Marital Status: Shoe size: Height: Weight:

Address: City: Zip:

Home ☎: Cell ☎:

Employer: Work ☎:

email:

☐ *Please check to receive appointment reminders / e-newsletter*

Policy Holder Information (❑ Check if same as patient)

First Name: M.I.: Last Name: Sex: M / F

SS#: DOB: Home ☎: Cell ☎:

Address: City: Zip:

Employer: Work ☎:

Guarantor Information (❑ Check if same as patient)

First Name: M.I.: Last Name: Sex: M / F

SS#: DOB: Home ☎: Cell ☎:

Address:	City:	Zip:
Employer:	Work ☎:	

Assignment of Benefits & Authorization to Release Information

If I am entitled to benefits under the Medicare, the Medicaid, or any insurance policy or other health benefit plan (covering me or anyone legally responsible for me), in consideration for services provided to me by Foot & Ankle Reconstruction (FAR), I assign, transfer and convey the benefits payable under such program, policy or plan for services rendered to me. I authorize payment of benefits directly to FAR, with such benefits to be applied to my bill. **I understand and acknowledge that this assignment does not relieve me of financial responsibility for charges incurred by me or anyone on my behalf, and I hereby acknowledge responsibility for and agree to pay charges not paid under this assignment, including any coinsurance amounts, deductibles, Durable Medical Equipment and any charges for services deemed to be noncovered, not precertified or not preauthorized by my insurance plan.**

_____ *(initial)* I give my consent for examination and treatment by Foot & Ankle Reconstruction

_____ *(initial)* I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read and understood the Notice.

_____ *(initial)* I acknowledge that I have received and read the Financial Policy of FAR

Responsible Party Signature_____

Relationship_____ Date_____/_____/_____

Witness _____ Date_____/_____/_____

Medical History

Name: _____ Date: _____

Please list any specific problems you want to discuss with the doctor? _____

_____

How long have you had this problem? _____

What is the nature of your pain? ❑ Sharp ❑ Dull ❑ Aching ❑ Burning ❑ Radiating ❑ Itching ❑ Stabbing ❑ Other _____

Is there a history of injury? ❑ Y ❑ N Date of injury? _____Is this a work related injury? ❑ Y ❑ N

Is your condition getting worse or better? _____ Rate your pain: **0 1 2 3 4 5 6 7 8 9 10** (severe)

What seems to make the condition / pain worse? _____

What seems to make the condition / pain better? _____

Have you seen any other physician for this problem? _____

Please list any treatments you have had for this condition: _____

Has this condition affected your ability to work, exercise or perform other daily activities? ❑ Y ❑ N
If so, how? _____

Past Medical History

(Please check all that applies)

❑ High blood pressure	❑ Sickle cell	❑ Leukemia/Lymphoma	❑ Crohn's disease
❑ Stroke / TIA	❑ Thalassemia	❑ Colitis	❑ Ulcerative colitis
❑ Angina / heart attack	❑ Diabetes	❑ Multiple sclerosis	❑ Lyme disease
❑ Heart rhythm disorder	❑ Eye disease	❑ Cerebral palsy	❑ HIV / AIDS
❑ Heart valve problem	❑ Kidney disease/dialysis	❑ Polio	❑ Syphilis
❑ Heart failure	❑ Neuropathy	❑ Seizure / Epilepsy	❑ Liver disease / Hepatitis B or C
❑ Asthma / COPD	❑ Thyroid disorder	❑ Muscular dystrophy	❑ Tuberculosis
❑ Blood clot in vein	❑ High cholesterol	❑ Panic/anxiety disorder	❑ Rheumatic fever
❑ Pulmonary embolus	❑ Osteoarthritis	❑ Bipolar illness/depression	❑ Sleep apnea
❑ Chronic bronchitis	❑ Lupus / SLE	❑ Psychiatric illness	❑ Back trouble / Sciatica
❑ Sarcoidosis	❑ Rheumatoid arthritis	❑ Dementia/Alzheimer's	❑ Skin disorder
❑ Raynaud's	❑ Psoriasis	❑ Stomach ulcers	❑ Use of steroids in the past 6 months
❑ Anemia	❑ Gout	❑ Reflux / GERD	❑ Other medical problems:
❑ Blood transfusion	❑ Cancer Type:	❑ Spinal cord injury Level:	
❑ Bleeding tendency			

Please list all previous surgeries and hospitalizations:

❑ Tonsils / adenoids	❑ Amputation	❑ Other vascular bypass
❑ Appendix	❑ Gallbladder	❑ Other:
❑ Hysterectomy	❑ Hernia	
❑ Angioplasty (balloon/stent)	❑ Coronary (heart) bypass	

Have you ever had difficulty with anesthesia? ❑ Y ❑ N Bleeding problems after surgery? ❑ Y ❑ N

List or attach a complete list of all current Medications:

Last tetanus immunization: Date_____ ❑ Unknown ❑ <5 years ❑ <10 years
Pneumonia vaccination: Yes____ No____
Flu vaccination: Yes____ No____
Allergies: ❑ None ❑ Penicillin ❑ Sulfa ❑ Aspirin ❑ Contrast ❑ Latex ❑ Iodine ❑ Shellfish ❑ Tape
q Gluten intolerance ❑ Food allergies ❑ Metal Other:_____

Social History:
q Married ❑ Single ❑ Widowed ❑ Divorced ❑ Partnered
Have you ever used illicit drugs? ❑ Y ❑ N Abused prescription medications, drug or alcohol? ❑ Y ❑ N
Do you ever drink alcohol? ❑ Y ❑ N How often? _____ How much? _____
Have you ever used tobacco? ❑ Y ❑ N amount per day: _____ Age began: _____ Quit at age: _____
What is your occupation? _____ Are you retired? ❑ Y ❑ N Disabled? ❑ Y ❑ N
Currently using hormones or oral contraceptives? ❑ Y ❑ N ❑ N/A
Women: Breastfeeding? ❑ Y ❑ N Could you be pregnant now? ❑ Y ❑ N

Are there any diseases / illnesses that seem common or run in your family? _____
_____

Please check pertinent issues you have had recently or frequently:

❑ Fever, chills	❑ Pain with breathing	❑ Kidney stones	❑ Dizziness
❑ Weight change	❑ Difficulty breathing when lying down	❑ Pelvic pain	❑ Dry skin / itching / rash
❑ Heat/cold intolerance		❑ Thick scar / keloid	❑ Hives/urticaria
❑ Night sweats	❑ Pain/bleeding/difficulty with urination	❑ Constipation	❑ Enlarged lymph nodes
❑ Headaches/Migraine		❑ Eating disorder	❑ Depression
❑ Nasal congestion	❑ Nausea / vomiting	❑ Abdominal pain	❑ Claustrophobia
❑ Nasal bleeding	❑ Vision blurring	❑ Loss of sensation	❑ Sleep disorder
❑ Sinus problems	❑ Osteomyelitis	❑ Diarrhea	❑ Leg pain with exertion or at night
❑ Sore throat	❑ MRSA	❑ Rectal bleeding	❑ Poor balance
❑ Easy bruising	❑ Previous foot/leg wound	❑ Chest pain with exertion	❑ Numbness/tingling/burning of feet
❑ Difficulty swallowing	❑ Leg swelling	❑ Varicose veins	❑ Sexually transmitted disease
❑ Heartburn	❑ Previous pressure ulcer	❑ Palpitations	❑ Hearing loss
❑ Shortness of breath	❑ Muscle weakness	❑ Cardiac arrest	❑ Tinnitus (ringing in ears)
❑ Wheezing	❑ Joint pain/swelling	❑ Pacemaker/defibrillator	❑ Language, cultural, or religious concerns
❑ Pain with cough	❑ Fatigue	❑ Immune disorder	