



PATIENT INFORMATION SHEET:

MR# _____

Last Name: _____ First Name/MI: _____

Street _____

City _____ State _____ Zip _____

Phone: () _____ - _____ Cell: () _____ - _____ Social Security #: _____

Sex: M F Birthdate: _____ Marital Status: Single ___ Married ___ Widowed ___ Other _____

Employer: _____ Occupation _____

Work phone: () _____ - _____ DL State _____ Number _____

Spouse Name: _____ Birthdate _____

Employer: _____ Business phone: () _____ - _____

Responsible Party (If Other Than Patient or Spouse): Wife Husband Parent Other

Last Name: _____ First Name/MI: _____

Street: _____ City/State: _____ Zip: _____

Phone: () _____ - _____ Birthdate: _____

Who May We Thank For Referring You To Our Office? _____

Television commercial _____ Internet _____ Yellow Pages _____

Your Primary Care Physician: _____ Phone: () _____ - _____

Who May We Contact In Case Of An Emergency? _____

Phone #: () _____ - _____

I authorize the release of any medical information necessary to process any claim. I authorize payment of benefits either to myself or to Triad Foot Center, PA as agreed upon at the time of treatment for services rendered. I understand I am liable for any deductibles, copays or non-covered services. I also verify I have provided The Triad Foot Center with my correct insurance information. If it is incorrect, I will be responsible for the full monetary amount of all my services. This authorization shall be valid unless rescinded by one at a later date.

Signature: _____ Date: _____

ALL COPAYMENTS ARE DUE AT THE TIME OF SERVICE



PATIENT HEALTH HISTORY

MR# _____

PATIENT NAME _____

DOB _____

AGE _____ GENDER _____ HEIGHT _____ WEIGHT _____ SHOE SIZE _____

FAMILY PHYSICIAN: _____ DATE OF LAST VISIT: _____

WHY ARE YOU HERE TODAY? _____

ANSWER YES or NO: Are you pregnant? _____ Do you have HIV? _____

Do you have diabetes? _____ Family member with diabetes? _____

LIST PAST SURGERIES _____

REVIEW OF SYSTEMS AND MEDICAL CONDITIONS:

PLEASE CHECK ANY THAT APPLY

HEENT

- None
- Glaucoma
- Sore Throat/ Difficulty Swallowing
- Dizziness
- Nose Bleeds
- Hearing Loss or Ringing
- Sinus Problems
- Other _____

MUSCULOSKELETAL

- None
- Gout
- Muscle Pain or Cramps
- Osteoarthritis
- Rheumatoid Arthritis
- Osteoporosis
- Swelling of the feet or legs
- Other _____

ENDOCRINE

- None
- Thyroid Disease
- Diabetes
- Other _____

CONSTITUTIONAL

- None
- Recent Weight Change
- Fatigue
- Night Sweats
- Fever
- Other _____

CARDIOVASCULAR

- None
- Angina
- Calf Pain When Walking
- Poor Circulation
- Blood Clots Legs/Lung
- Peripheral Artery Disease
- High or Low Blood Pressure
- History of Heart Attack/Stroke

Dates: _____

- Chest Pain
- Palpitations
- Other _____

GENITOURINARY

- None
- Kidney Disease
- Bladder Problems
- Other _____

SKIN

- None
- Change in Hair or Nails
- Thick Scars
- Open Sores
- Rashes
- Skin Cancer
- Other _____

RESPIRATORY

- None
- Asthma
- Cough
- Difficulty Breathing
- Emphysema
- Other _____

GASTROINTESTINAL

- None
- Irritable Bowel Syndrome
- Stomach Ulcer
- Reflux
- Liver Disease

HEMATOLOGIC

- None
- Anemia
- Bruise Easily
- Blood Clotting Disorder
- Slow To Heal
- Other _____

NEUROLOGICAL / PSYCHIATRIC

- None
- Frequent Headaches/Migraines
- Seizures or Convulsions
- Depression
- Paralysis or Tremors
- Anxiety
- Memory Loss

SOCIAL HISTORY & DAILY LIVING

PLEASE CHECK ANY THAT APPLY PAST OR PRESENT

TOBACCO USE Yes No Past _____ PACK PER DAY _____ YEARS

STOPPED / LAST USE: _____

ALCOHOL USE Yes No Social LESS THAN 2 DRINKS PER DAY

STOPPED / LAST USE: _____ MORE THAN 2 DRINKS PER DAY

RECREATIONAL DRUG USE Yes No Past

STOPPED / LAST USE: _____

FAMILY INFORMATION

MOTHER: living; current age _____ or deceased; age at time of death _____

cause of death: _____

FATHER: living; current age _____ or deceased; age at time of death _____

cause of death: _____

Please check if there is a history with either parent (indicate which one) for any of the following:

CANCER _____ BLOOD CLOTS _____

BLEEDING PROBLEMS _____ DIABETES _____

STROKE _____ HIGH BLOOD PRESSURE _____

RHEUMATOID ARTHRITIS _____ GOUT _____

PROBLEMS WITH ANESTHESIA _____

I have read and understand the patient information forms. The information that I have provided in these forms is correct to the best of my knowledge.

Patient Signature

Date

If the patient is a minor (under 18 years of age) or is otherwise unable to sign on their own behalf, the patient representative who completed these forms should complete the following information:

Patient Signature Name

Signature

Relationship to Patient: _____

Authorization for Release of Information

Name of Patient _____ Date of Birth _____

_____ is authorized to release protected health information about the above named patient to the entities named below. The purpose is to inform the patient or others in keeping with the patient's instructions.

Entity to Receive Information. Check each person/entity that you approve to receive information.	Description of information to be released. Check each that can be given to person/entity on the left in the same section.
<input type="checkbox"/> Voice Mail	<input type="checkbox"/> Results of lab tests/x-rays <input type="checkbox"/> Other _____
<input type="checkbox"/> Spouse	<input type="checkbox"/> Financial <input type="checkbox"/> Medical as follows: _____
<input type="checkbox"/> Parent (provide name) _____	<input type="checkbox"/> Financial <input type="checkbox"/> Medical as follows: _____
<input type="checkbox"/> Other (provide name) _____ _____	<input type="checkbox"/> Financial <input type="checkbox"/> Medical as follows: _____

Patient Information

I understand that I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed as described in this document, I understand that a revocation is not effective in cases where the information has already been disclosed but will be effective going forward.

I understand that information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.

I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing. This authorization shall be in effect until revoked by the patient.

_____ Date _____

Signature of Patient or Personal Representative
 Description of Personal Representative's Authority (attach necessary documentation)



PATIENT MEDICATION LIST

Date _____

MR# _____

PATIENT NAME _____ **DOB** _____

Pharmacy Name _____ Phone # _____

Medication

Medication

ALLERGIES: **NONE (No Known Allergies)** **SEASONAL ALLERGIES**

PENICILLIN SULFA IODINE ASPIRIN ANESTHETICS

LATEX CODEINE DEMEROL DARVOCET CORTISONE

ADHESIVE TAPE FOOD ENVIRONMENTAL OTHER _____

TYPE OF REACTIONS _____



Acknowledgement of Receipt Of Notice of Privacy Practices

Patient Name & Address: _____

I have received a copy of the Notice of Privacy Practices for the above named practice.

Signature Date

For Office Use Only

We were unable to obtain a written acknowledgement of receipt of the Notice of Privacy Practices because:

- An emergency existed & a signature was not possible at the time.
- The individual refused to sign.
- A copy was mailed with a request for a signature by return mail.
- Unable to communicate with the patient for the following reason:

Other: _____

Prepared By _____

Signature _____

Date _____
