PATIENT NAME: DOB: PATIENT ACCT #:

atient Account #:

Sandhills Foot Clinic

I give consent to access my pharmacy records.

PATIENT INFORMATION:

Last Name: First Name: Middle Initial:

Prefer to be called: Maiden Name:

Suffix / Prefix:

Credentials:

Male Female SS#:

Age:

RACE / ETHNICITY:

Asian African American Caucasian Hispanic Pacific Islander Native American Other

PRIMARY LANGUAGE:

English Spanish Other

MARITAL STATUS:

Single Married Divorced Partnered Widowed

CONTACT INFORMATION:

Address:

City, State, Zip: County:

Please check the primary number.

PATIENT NAME: DOB: PATIENT ACCT #:

Home Work Cell

May we leave a message? Yes No

Email Address:

Preferred Method of Communication: Phone Email Mail Patient Portal

Emergency Contact Name: Emergency Phone:

Relationship: Spouse Parent Sibling Friend Other

PRIMARY PHYSICIAN INFORMATION:

*Primary Physician:

Referring Physician:

Primary Physician Phone: Referring Physician Phone:

Primary Physician Fax: Referring Physician Fax:

Date of your last visit:

Influenza Vaccination: Yes No Date

Pneumonia Vaccination: Yes No Date

History of MRSA Infection: Yes No

PRIMARY INSURANCE:

Policy Holder:

Self Policy Holder Name (if not patient):

Relationship to patient:

Spouse Parent Legal Guardian Partner Other

Policy Holder Date of Birth: Policy Holder SS#:

Insurance Plan Name: Insurance Policy #:

Insurance Group #: Effective Date:

Co-payment Amount: Deductible: Co-Insurance (%):

SECONDARY INSURANCE:

Policy Holder:

Self Policy Holder Name (if not patient):

Relationship to patient:

Spouse Parent Legal Guardian Partner Other

Policy Holder Date of Birth: Policy Holder SS#:

Insurance Plan Name: Insurance Policy #:

Insurance Group #: Effective Date:

Co-payment Amount: Deductible: Co-Insurance (%):

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 Sandhills Foot Clinic (SFC), 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 SFC, 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 Sandhills Foot Clinic.

_____ (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 SFC.

_____ (initial) I authorize the release of information including the diagnosis, records, examination, treatment, radiology, and claims information.
This information may be released to:

Spouse Family Friend Other Treating Physician(s) Do Not Release my Medical Information to Anyone

Patient Signature:

_____

Printed Name:

If patient is 18 years of age or younger, please provide Parent/Guardian Signature:

_____

Printed Name: Relationship:

Witness Signature: _____ Date:

PATIENT NAME: DOB: PATIENT ACCT #:

PATIENT NAME: DOB: PATIENT ACCT #:

PRIMARY COMPLAINT:

What is your primary complaint? (Please answer all questions):

Location:

Right Left

Great toe Lesser toe Ball of foot Top of foot

Arch Heel Ankle Leg

Nature of the Pain (Please answer all questions):

Sharp Dull Aching Burning

Radiating Stabbing Itching Other

Pain Scale:

Low 0 1 2 3 4 5 6 7 8 9 10 **High**

Swelling:

None Mild Moderate Severe

PREVIOUS TREATMENT:

Have you had previous treatment for this problem?

Yes No

If yes, what treatments? Please list doctor's name

Do you have any other complaints or problems?

Yes No

If yes, please list:

GENERAL PATIENT INFORMATION:

Height Weight Shoe Size

ONSET:

When did the problem start?

Suddenly Gradually

Duration:

Days Weeks Months Years

COURSE:

Is this problem related to an injury? **Work related?**

Yes No Yes No

If yes, when? Activity causing injury:

Getting worse Improving

Stays the same Comes and goes

What makes it better?

Makes it worse?

Standing Walking Running

Daily activities Exercise Work

Shoes

Does this problem affect your daily activity?

Yes No

If yes, how?

Illness
Alcoholism
Cancer
Diabetes
Elevated Cholesterol
Hepatitis B
Hepatitis C
HIV / AIDS
Hyperthyroidism
Hypo (low) thyroid
Liver Disease / Cirrhois
Lyme Disease
Lymphoma
Malignant Hyperthermia
Rheumatic Fever

Cardiac
Angina
Arrhythmia
Atrial Fibrillation
Cardiac Arrest (heart attack)
Congenital Heart Disease
Congestive Heart Failure
Coronary Artery Disease
Fainting / Syncope
Heart Disease
Heart Murmur
Heart Valve Replacement
High Blood Pressure
Low Blood Pressure
Mitral Valve Prolapse
Myocardial Infarction
Pacemaker / Defibrillator

Vascular
Blood Clots
Cellulitis
DVT (deep vein thrombosis)
Greenfield Filter
Leg Swelling
Leg Ulcers
Lymphedema
Peripheral Artery Disease
Phlebitis
Poor Circulation
Pulmonary Embolism
Raynaud's
Spider Veins
Varicose Veins
Vasculitis
Vein Problems

Blood / Hematologic
Anemia
Bleeding Disorder
Hemophilia
Leukemia
Previous Transfusion
Sickle Cell Disease

Respiratory
Asthma
Bronchitis
COPD
CPAP
Cystic Fibrosis
Emphysema
Pneumonia
Sarcoidosis
Sleep Apnea
Tuberculosis

EENT
Blindness
Cataract
Eye Disease
Glaucoma
Hearing Loss
Macular Degeneration
Migraine Headaches
Nasal Polyps
Sinus Headaches
Sinus Infection
Tinnitus

GI (Gastrointestinal)
Acid Reflux/GERD
Colitis
Crohn's Disease
Diverticulitis
Duodenal Ulcer
Gallbladder Disease
Gastric By-Pass Surgery
Gastric Ulcer
Hemorrhoids
Hiatal Hernia
Ulcerative Colitis
Irritable Bowel Syndrome

GU (Gentourinary)
Bladder Infections
Cystic Kidney Disease
Kidney Infections
Kidney Stones
Prostate Disease
Renal Insufficiency
Renal / Kidney Failure
STD
Syphillis

Musculoskeletal
Achilles Tendonitis
Amputation - Foot / Toes
Amputation - Leg
Ankle Sprain
Back Pain
Bunion
Bursitis
Charcot Foot Deformity
Club Foot
Difficulty Walking
Dislocation - Foot / Ankle
Dropfoot
Fibromyalgia
Foot Sprain Fracture
Ankle Fracture - Toes / Foot
Fracture - Leg
Ganglion
Gout
Hammertoe
Heel Spur
Joint Instability
Joint Stiffness
Lupus (SLE)
Muscle Spasms
Osteoarthritis
Osteopenia
Osteoporosis
Plantar Fascitis
Psoriatic Arthritis
Rheumatoid Arthritis
Rupture - Achilles Tendon
Shin Splints
Tailor's Bunion
Tendonitis, Other
Unequal Leg Length

Neuro / Psych
Alzheimer's Disease
Anorexia
Anxiety Disorder
Bi-Polar Disorder
Brain Injury
Cerrebral palsy
Charcot-Marie-Toothe Disease
Dementia
Depression
Diabetic Neuropathy
Drug Abuse
Drug Dependency
Epilepsy
Hemiplegia
Idiopathic Neuropathy
Multiple Sclerosis
Muscular Dystrophy
Pain Management
Panic Disorder
Paraplegia
Parkinson's Disease
Polio
Poor Balance
Psychotherapy/Medications
Ruptured Disc
Schizophrenia
Sciatica
Seizure Disorder
Spina Bifida
Spinal Cord Injury
Stroke
TIA
Tremors
Vertigo

Skin
Acne
Athlete's Foot
Contact Dermatitis
Dermatitis
Eczema
Fungal Nail Infection
Fungal Skin Infection
Hyperkeratosis Plantaris
Ingrown Toenail
Keloid / Scarring
Malignant Melanoma
Psoriasis
Rash
Scleroderma
Skin Cancer
Skin Disorders
Warts
Vitiligo

PATIENT NAME: DOB: PATIENT ACCT #:

FAMILY MEDICAL HISTORY:

	Mother	Father	Brother	Sister	Son	Daughter
Heart Disease						
Arthritis						
Asthma						
Cancer						
Diabetes						
Hypertension						
Other:						

SOCIAL HISTORY:

Single Married Partnered Separated Divorced Widowed

Tobacco Use: (please choose one)

Never Former (Quit date) Current (How many years?) Packs/day:

Alcohol Use: (please choose one)

Never Rare Occasional Moderate Daily
Drinks/week:

Illicit Drug Use: Yes No Drugs used: **Prescription**

Drug Abuse: Yes No Drugs used:

Occupation: **Employer:**

Time on your feet during the day: Minimal 25% 50% 75% 100%

Do you exercise? Sedentary Minimal Active but no formal exercise Heavy

Type of exercise: **How many times a week?**

CURRENT MEDICATIONS:

Medication Dosage

* If more medications, please attach with paperwork

DRUG ALLERGIES:

No allergies

Penicillin Sulfa Bactrim Amoxicillin Keflex
Erythromycin Neosporin Cipro

Other Antibiotic(s): please list:

Iodine Betadine Shellfish Contrast Dye Codeine Demerol

Aspirin Hydrocodone Latex Tape Skin Adhesives Metal

Anti-inflammato

OTHER KNOWN ALLERGIES:

Food:

PATIENT NAME: DOB: PATIENT ACCT #:

Environmental:

Other: Review of Systems

Constitutional
Fatigue
Malaise
Weight Loss
Fever
Body Aches
Chills
Night Sweats
Loss of Appetite

Eyes
Discharge from Eye
Double Vision
Floaters
Eye Discomfort/Pain
Impaired Vision
Foreign Body Sensation
Blurred Vision
Changes in Vision

HENT
Headaches
Nasal Discharge
Recent Head Injury
Sore Throat
Nose Bleeding
Dental or Gum Disease
Lightheadedness
Neck Stiffness
Nasal Congestion
Thyroid Mass
Dentures
Dizziness
Neck Pain
Sinus Pain
Hoarseness

Cardiovascular
Chest Pain
Syncope / Fainting
Varicose Veins
Pacemaker / Defibrillator
Irregular Heartbeat
Shortness of breath - Exertion
Lower Extremity Edema
Cardiac Arrest
Slow or Rapid Heartbeat

Respiratory
Shortness of Breath
Pain with Breathing
Painful Cough
Productive Cough
Difficulty Breathing
Coughing up Blood
Wheezing

Gastrointestinal
Nausea
Constipation
Blood in Stools
Abdominal Pain
Vomiting
Gallstones
Heartburn
Black Stools
Diarrhea
Loss of Appetite
Jaundice
Eating Disorder

Gentourinary
Urinary Frequency
Possible Pregnancy
Painful/Difficulty Urinating
Blood in Urine
Kidney Stones
Pelvic Pain

Integument
Rash
Dry Skin
Acne
Itching
Change/Loss Hair Growth Skin/Mole Changes in Pigmentation
Discolored, Thickened, or Damaged Nails
Blisters
Ingrown Nail

Neurologic
Muscle Weakness
Loss of Muscle Control
Loss of Coordination
Loss of Balance
Numbness
Tingling
Tremors
Seizures
Dizziness
Paralysis
Difficulty with Speech
Loss of Consciousness
Loss of Sensation
Memory Loss/Confusion

Musculoskeletal
Muscle Weakness
Joint Stiffness
Joint Swelling
Muscle Cramps
Limitation of Motion
Leg Swelling
Instability
Ankle Weakness and/or Leg Pain
Foot Pain
Ankle Pain
Knee Pain
Leg Pain
Hip Pain
Joint Pain/Other

Endocrine
Cold Intolerance
Heat Intolerance
Loss of Hair
Weight Gain / Loss

Psychiatric
Anxiety
Depression
Bi-polar
Difficulty Sleeping
Hallucinations

Heme-Lymph
Easy Bleeding
Easy Bruising
Enlarged Lymph Nodes

Website Other

How did you hear about Sandhills Foot Clinic?

Signature Date