WHITE BEAR FOOT AND ANKLE CLINIC HEALTH QUESTIONNAIRE

NAME_____ DATE_____

REFERRED BY_____

CHIEF FOOT COMPLAINT_____ DURATION_____

ANY FOOT INJURIES_____

ANY PREVIOUS TREATMENT(describe)_____

HEIGHT_____ WEIGHT_____ SHOE SIZE _____

IS THIS A WORK RELATED INJURY? Yes_____ No_____

DO YOU NOW HAVE OR HAVE YOU EVER HAD ANY OF THE FOLLOWING? (leave blank if NO)

___heart disease
___high blood pressure
___hardening of the arteries
___circulatory problems
___stroke
___varicose veins
___blood clots
___phlebitis
___excessive bleeding problems
___anemia
___asthma
___emphysema
___other lung problems
___kidney problems
___urinary tract problems
___stomach problems
___ulcers
___intestinal system problems
___liver disease
___hepatitis
___HIV
___thyroid problems
___diabetes
___gout
___arthritis
___back problems
___sciatica
___slow healing
___excessive or painful scarring

ANY OTHER MEDICAL ISSUES_____

LIST ANY MEDICATIONS YOU ARE TAKING_____

_____

LIST ANY ALLERGIES TO MEDICATIONS_____

PAST SURGERIES_____

ANY PROBLEMS WITH ANAESTHESIA_____

ANY FAMILY HISTORY OF ANAESTHESIA PROBLEMS_____

ANY FAMILY HISTORY OF MEDICAL PROBLEMS_____

ANY FAMILY HISTORY OF FOOT PROBLEMS_____

OCCUPATION_____

RECREATIONAL ACTIVITIES_____

TOBACCO USAGE: NEVER SMOKED_____ FORMER SMOKER_____ DATE QUIT_____

CURRENT SMOKER_____ PACKS PER DAY_____ FOR HOW MANY YEARS_____

DO YOU USE ALCOHOL? _____ HOW MANY DRINKS PER WEEK? _____

White Bear Foot and Ankle Clinic Inc - Consent For Treatment

I voluntarily consent to evaluation, treatment, diagnostic testing, medication, nursing care and/or therapy which my physician or his/ her designees determine to be necessary. I understand that the practice of medicine is not an exact science and I acknowledge no guarantees have been made to me as the result of examination or treatment in the clinic. I consent to the release of information about my medical care to any health care provider involved with my current treatment.

I authorize the White Bear Foot and Ankle Clinic to bill my insurance company and authorize my insurance benefits to be paid directly to White Bear Foot and Ankle Clinic. I agree to be responsible to pay any non-covered services or all charges if there is no insurance coverage. I authorize the release of pertinent medical information to insurance carriers, health maintenance organizations, government payers or third party administrators for billing fraud investigations or quality of care purposes.

I understand that when standard procedures for collection of revenues have been exhausted, additional collection services will be utilized, and you will be responsible for any fees or interest charges added to your balance. If your check payment is returned due to insufficient funds, we will charge you for any bank fees applicable.

X_____ _____

Signature of Patient (or Authorized Representative) **Date**

White Bear Foot and Ankle Clinic Inc – HIPAA NOTICE

I have been provided a copy of HIPAA guidelines which I have read and understand.

X_____ _____

Signature of Patient (or Authorized Representative) **Date**

White Bear Foot and Ankle Clinic Inc – Disclosure of information

I authorize White Bear Foot and Ankle Clinic, Inc. to discuss my treatment and/or conditions with:

_____ _____ _____

Name Relationship Phone Number

X_____ _____

Signature of Patient (or Authorized Representative) **Date**

WELCOME TO WHITE BEAR FOOT AND ANKLE CLINIC

We are pleased to welcome you to our office. Please take a few minutes to fill out this as completely as possible as it will help us give you the best care. We look forward to working with you in maintaining your foot health.

Patient Information- PLEASE PRINT CLEARLY

Name_____
Last Name First name Middle Initial

Address_____

City_____ State_____ Zip_____ Home Phone ( )_____

Sex F___ M___ Age _____ Birth Date _____ Cell Phone ( )_____

Email_____

Preferred method of communication: Cell phone_____ Home phone_____ Email_____

I consent to receive automated appointment text reminders/messages at phone # listed above: Yes No

Employer_____ Business Phone ( )_____

Emergency Contact _____ Relationship _____Phone ( )_____

Primary Physician/Clinic _____Date Last Seen _____

Name of Pharmacy _____ Location _____

Responsible Party

Person Responsible for the Account_____Relationship_____

Address (if different from patient) _____

City_____ State_____ Zip_____ Phone ( )_____

Birth Date _____ Employer_____ Phone ( )_____

Insurance Company_____ Member ID #_____ Group #_____

The following information is requested to comply with federal regulations:

Preferred Language_____ Decline to specify _____

Ethnicity/Race: Hispanic or Latino_____ American Indian or Alaska Native _____ Asian _____

Black or African American _____Native Hawaiian or Pacific Islander _____ White _____

Decline to specify _____