Dr. Tom's Foot & Ankle
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New Patient Paperwork

Patient Information

Name: _____ Gender: **M F**

Date of Birth: ___/___/_____ Age: _____ Social Security #: _____ - ___ - _____

Address: _____ Zip: _____

Home Phone: (____) _____ - _____ Cell/Work Phone: (____) _____ - _____

Email Address: _____

Marital Status: **Married** **Single** **Separated** **Divorced** **Widow/Widower**

How did you hear about us?

___ Internet
___ Radio
___ TV
___ Phone Book
___ Print Advertising
___ Existing Patient: _____
___ Friend/Family: _____
___ Referring Physician: _____

Emergency Contact Information

Name: _____ Relationship to patient: _____

Primary Phone:(____) _____ - _____ Secondary Phone:(____) _____ - _____

Responsible Party Information / Insurance Policy Holder Information

(***If person other than patient***)

Name: _____ Date of Birth _____/_____/_____

Relationship to patient: _____ Social Security # ____-____-_____

Address: _____

Primary Phone:(____) _____ - _____ Secondary Phone:(____) _____ - _____

Primary Care Physician

Physician Name _____ Practice _____

Allergies

___ No Known Drug Allergies

I am allergic to (Please check)

___ Penicillin ___ Aspirin ___ Novocaine/Lidocaine

___ Sulfa ___ Codeine ___Adhesives/Tape

___ Latex ___ Iodine/Shellfish ___ Other: _____

Personal Medical History

Check all that apply to you now or have applied to you in the past

___ Liver Disorder ___ Hepatitis A B C

___ Kidney Disease ___ HIV

___ Dialysis ___ **Prolonged Bleeding Time**

___ **Diabetes** *Average blood sugar* _____ ___ **Blood Clots**

___ **Gout**

Medications

Please list all prescribed medications and their dosages that you are currently taking
___ Not taking any prescribed medications
___See attached List

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____

Specialist

Are you currently being treated or have have been treated in the past by any of the following Specialist? (Check all that apply)

___ Neurologist Name/Office: _____

___ Reumatologist Name/Office: _____

___ Physical Therapist Name/Office: _____

___ Orthopedic Name/Office: _____

___ Wound Center Name/Office: _____

___ Other Name/Office: _____

Social History

Do you currently smoke? **Yes No** How many packs per day? _____ Years? _____

Have you smoked previously? **Yes No** When did you quit? _____

Number of caffeine drinks per day? _____

Do you drink alcohol currently? **Yes No** How often during the week? _____

Do you currently use any recreational drugs? **Yes No**

For women only: are you pregnant? **Yes No** How many months? _____

Family Medical History

Has any of your family members had any of the following (please indicate relationship)

Diabetes: _____ Arthritis: _____

Blood Clots/Stroke: _____ Cancer: _____

High Blood Pressure: _____ Liver/Kidney Disease: _____

Foot Problems: _____ Other: _____

I certify that the above information is true and correct to the best of my knowledge. I give my permission to the doctor to administer and perform such procedures as may be deemed necessary in the diagnosis and/or treatment of my feet, ankles or lower legs. **I hereby authorize medical information to be sent to my primary physician.** I authorize Dr. Tom's Foot and Ankle to bill my insurance on file for all services rendered and products (including DME) dispensed. **If my insurance does not pay the full amount of the bill I understand that the remainder of the balance will be my responsibility.**

SIGNATURE: _____ DATE: _____

If signing for a minor, please list your relationship to the patient: _____

HIPAA Compliance

Please list below the name(s) of any individual(s) to whom you authorize us to verbally discuss your medical information (e.g. lab or test result, appointment date/time, prescription information) in person or over the phone. This does not authorize the release of physical or digital copies of medical records.

Name: _____ Relationship to patient: _____

Name: _____ Relationship to patient: _____

Name: _____ Relationship to patient: _____

_____ Check here if you **do not want** your health information discussed with anyone other than yourself.

SIGNATURE: _____ DATE: _____

If signing for a minor, please list your relationship to the patient: _____