Summit Foot and Ankle

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Name: _____ DOB: _____ Chart Number: _____

Sex: ❒M ❒ F Marital Status: ❒ Single ❒ Married ❒ Widowed ❒ Divorced SS#: _____

Email: _____ Spouse / Partner Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Home #: _____ Cell #: _____ Other # : _____

Employer: _____ Phone: _____

Employer Address: _____ City: _____ State: _____ Zip: _____

Emergency Name: _____ Phone: _____

Relationship:_____

How did you find out about our practice?

❒ Physician Referral ❒ Website/Google ❒ Facebook ❒ Instagram ❒ Family Member/Friend

Primary Insurance: _____ Are you the insured?: ❒Yes ❒No

Insured Information

Subscriber Name: _____ Relationship to insured: ❒ Spouse ❒ Child ❒ Self ❒ Other

Phone #: _____ Sex: ❒Male ❒Female DOB: _____

Address: _____

Policy ID: _____ Group ID: _____ Employer: _____

Secondary Insurance: _____ Are you the insured?: ❒Yes ❒No

Insured Information

Subscriber Name: _____ Relationship to insured: ❒ Spouse ❒ Child ❒ Self ❒ Other

Phone #: _____ Sex: ❒Male ❒Female DOB: _____

Address: _____

Policy ID: _____ Group ID: _____ Employer: _____

Ethnicity: ❒Hispanic or Latino ❒Not Hispanic or Latino ❒Declined to specify

Race: ❒Asian ❒American Indian or Alaska Native ❒Black or African American
❒White ❒Native Hawaiian or other Pacific Islander ❒Declined to specify

Preferred Language: _____ ❒Declined to specify

Pharmacy Name: _____ Pharmacy Phone: _____

Pharmacy Address: _____ City, State, Zip: _____

Primary Care Physician: _____ Phone: _____ Date Last Seen: _____

Address: _____

Referring Physician: _____ Phone: _____ Date Last Seen: _____

Address: _____

History and Physical **Name: _____ DOB: _____**

Medical History: ❒Alcoholism ❒Blood disorders ❒Circulation problems ❒Musculoskeletal ❒Breathing issues
❒Liver ❒Sleep apnea ❒Gout ❒Allergies ❒Heart disease ❒Asthma
❒Heart murmur ❒Stomach/bowel ❒Depression ❒Anxiety disorder ❒Mental illness ❒Kidney disease
❒Blood clot ❒High cholesterol ❒High blood pressure ❒Cancer ❒Hepatitis
❒Neuropathy (specify) _____ ❒Thyroid disease (specify) _____ ❒Diabetes (type 1, type 2)
❒Arthritis (specify) _____ ❒Other (specify) _____ ❒HIV ❒CVA
Are you pregnant? ❒Yes ❒No ❒Are you nursing? ❒Yes ❒No ❒Skin disorders ❒Stroke

Surgical History ❒None ❒Appendectomy ❒C-Section ❒Angioplasty ❒Bypass ❒Cataracts ❒Cholecystectomy
Have you ever had any surgical procedures on foot/ankle or anywhere else on your body? ❒Yes ❒No
If yes, please describe: _____
Do you have any artificial joints? ❒Yes (where? _____) ❒No Do you have an artificial heart valve? ❒Yes ❒No

Social History
Do you smoke? ❒Yes ❒No If yes, how many packs per day? ❒1/2 ❒1 ❒1 1/2 For how long? _____years
Do you drink alcohol? ❒Yes, everyday (5-7) days/week) ❒Yes, occasionally/social ❒No/Rarely
Substance Abuse: ❒Yes, I have a current substance abuse problem. Please specify: _____
❒Yes, I had a past substance abuse problem. Please specify: _____
❒No, I have never had a substance abuse problem.
What is your occupation? _____. Does it involve mostly ❒standing or ❒sitting
Do you exercise regularly? ❒No, I do not exercise regularly ❒Yes, I do the following regular exercise: _____
_____

Family History Is there any family history (blood relative) of: (Please indicate family member)

❒Alzheimer's	_____	❒ Depression	_____
❒Arthritis	_____	❒ Diabetes	_____
❒Bleeding disorders	_____	❒ Heart disease	_____
❒Cancer	_____	❒ High blood pressure	_____
❒Cataracts	_____	❒ Neurological	_____
❒Circulation problems	_____	❒ Strokes	_____
❒Other (specify)	_____		

Review of Systems (Please check the box if you currently have any of these symptoms or check "NONE")

Cardiovascular ❒leg pain when walking ❒fever ❒chest pain/pressure ❒leg swelling ❒cold hands/feet
❒palpitations ❒fainting ❒vascular disease ❒valve problems ❒NONE

Genitourinary ❒blood in urine ❒hesitancy ❒incontinence ❒increased urgency
❒decreased frequency ❒excessive urination ❒kidney disease ❒kidney stones ❒NONE

Gastrointestinal ❒abdominal pain ❒heartburn ❒diarrhea ❒vomiting ❒decreased appetite ❒ulcers
❒constipation ❒trouble swallowing ❒blood in stool ❒increased appetite ❒NONE

Integumentary ❒athlete's foot ❒keloids ❒itchiness ❒dry, scaly skin ❒nail abnormalities ❒NONE

Hematologic ❒anemia ❒lower leg ulcers ❒sickle cell disease ❒blood thinners ❒clotting disorders ❒NONE

Neurological ❒tingling ❒weakness ❒seizures ❒numbness ❒headaches ❒NONE
❒tremors ❒paralysis

Musculoskeletal ❒back pain ❒joint pain ❒neck pain ❒joint instability ❒muscle pain
❒joint stiffness ❒joint swelling ❒muscle weakness ❒sciatica ❒NONE

Respiratory ❒chest pain ❒wheezing ❒COPD ❒coughing ❒snoring ❒NONE
❒shortness of breath ❒emphysema

Name: _____ DOB: _____

Please describe your injury or primary complaint?

_____

_____

Result of accident or work injury? ❒**Yes** ❒**No**

How long has this bothered you? 1 2 3 4 5 6 7 (circle one) days weeks months years (circle one)

What treatments have you tried & have they been effective? _____

_____

On a scale of 1-10 (1 being no pain and 10 being the worst) what is your level of pain? ___ / 10

The pain quality is: ❒ burning ❒ constant ❒ dull ❒ sharp ❒ shooting ❒ throbbing ❒ tingling

Other:_____

Privacy Information Preference

Can we send mail to the address on file? ❒Yes ❒No

Can we call the phone number on file? ❒Yes ❒No Can we leave a voicemail on machine? ❒Yes ❒No

Will you allow us to send internet based (e-mail) delivery of reminders? ❒Yes ❒No

If yes, please provide your e-mail address: _____

Who can we leave a message with? ❒Wife ❒Husband ❒Daughter ❒Son ❒Other:

Names: _____

Shoe Size: _____ / Width: _____	Height: _____ / Weight: _____

Current Medications

❒ see list ❒I take the following medications

Name	Dose	Times per day

Use the back of this form if more room is needed.

Allergies

❒No Known Allergies ❒No Known Drug Allergies

Name	Reaction

Use the back of this form if more room is needed

Last Flu Shot Date: _____ **Did you get a pneumococcal vaccination?**❒Yes ❒No

Have you fallen in the last 12 months? ❒Yes ❒No **Were you injured from the fall?** ❒Yes ❒No

Have you completed any Advanced Directives ❒Yes ❒No

PLEASE READ AND SIGN: The information on my intake form(s) in correct to the best of my knowledge. I give permission to the doctor to administer and perform such procedures, including but not limited to therapeutic and diagnostic injections, as deemed necessary in the diagnosis and/or treatment of my condition. I understand that throughout my treatment, I am responsible for notifying the physician and/or medical staff of any and all updates to the information listed above. (Assignment of Benefits): I authorize payment of medical benefits to the practice named above. (Release of Information): I authorize the release of any medical information necessary to process this claim. (HIPAA Privacy): I acknowledge that I received my HIPAA Privacy Practices Notice. (Medication History): I authorize the Doctor's office to retrieve my medication history.

Patient Signature: _____ Date: _____

Print Name:_____

This document has been reviewed by Dr. Bauer.