PORTLAND FOOT & ANKLE

Personal and Emergency Information: Today's Date: _____

Patient Name: _____

Social Security #: _____ Date of Birth: _____

Address: _____
Street City State Zip

Birth Sex: ❒ Male ❒ Female Email Address: _____

Home Phone: _____ Ok to leave detailed message?* ❒ Yes ❒ No

Cell Phone: _____ Ok to leave detailed message?* ❒ Yes ❒ No

Work Phone: _____ Ok to leave detailed message?* ❒ Yes ❒ No

****Detailed messages may contain medical and/or prescription information.***

Please check preferred contact number: ❒ ***Home*** ❒ ***Cell*** ❒ ***Work***

Emergency Contact name, relationship, and phone number: _____

_____

Insurance Information:

Insurance Name: _____

Policy #: _____ Group #: _____

Subscriber Name: _____ Subscriber DOB: _____

Subscriber SSN: _____ Subscriber Employer: _____

How did you hear about Portland Foot & Ankle (check one)

❒ *Friend/Family* ❒ *Internet* ❒ *Yellow Pages* ❒ *Your PCP* ❒ *Radio* ❒ *TV* ❒ *Print Ad*

Primary Care Physician Information:

Primary Care Physician: _____

PCP City/Town: _____ PCP Phone #: _____

May we send reports/updates to your Primary Care Physician? ❒ Yes ❒ No

Foot and/or Ankle Issues:

Describe your foot/ankle problem: _____

_____

How long have you had this problem? _____

Have you had any treatments for this problem? If so, describe. _____

_____

Is there anything else you'd like us to know related to your visit today? _____

_____

Is there anything special you'd like to discuss with the doctor today? _____

_____

_____

All health care offices have been mandated to collect the following information under the American Recovery and Reinvestment Act of 2009 and subsequently the Meaningful Use regulations imposed by The Centers for Medicare & Medicaid Services. The information collected is de-identified and reported to The Centers for Medicare & Medicaid Services.

1. What is your primary language? ❒ English ❒ Spanish ❒ French

   ❒ Other:_____

2. Please select your race:
   - ❒ American Indian or Alaskan Native
   - ❒ Asian
   - ❒ Black or African American
   - ❒ White
   - ❒ Native Hawaiian or other Pacific Islander

3. Please select your ethnicity:
   - ❒ Hispanic or Latino
   - ❒ Not Hispanic or Latino

Pharmacy you most often use:

❒ CVS ❒ Rite Aid ❒ Walgreens ❒ Hannaford ❒ Shaw's ❒ Walmart

❒ Other: _____

What Town or City is your preferred pharmacy located in?:

_____

Name:_____ ***DOB***:_____

Today's Date: _____

Height _____ Weight _____ Shoe Size_____

PAST SURGICAL HISTORY ❒ No past surgeries
List all operations you have had:

_____

Have you ever had any problems with anesthesia? ❒Yes ❒No If yes, please explain_____

_____

FAMILY HEALTH
Have any blood relatives ever had the following? If so, please indicate their relationship to you in the column below.

		Father	Mother	Brother	Sister	Son	Daughter
Any Unusual Disease	❒Yes❒No						
Arthritis	❒Yes❒No						
Blood Disease	❒Yes❒No						
Cancer	❒Yes❒No						
Diabetes	❒Yes❒No						
Heart Trouble	❒Yes❒No						
High Blood Pressure	❒Yes❒No						
Liver Trouble	❒Yes❒No						
Malignant Hyperthermia	❒Yes❒No						
Psychiatric Disease	❒Yes❒No						
Tuberculosis	❒Yes❒No						
Unusual reaction to anesthesia	❒Yes❒No						

If your mother, father, or any brothers and/or sisters died, what was the cause of their death and their age at the time of death?

_____

CURRENT MEDICATIONS ❒ Not taking any
List all the medications you are now taking, including aspirin, pain medications, hormones, contraceptives, water pills, diet pills, vitamins, herbal medications, or sleeping pills.

MEDICATION	STRENGTH	FREQUENCY TAKEN	MEDICATION	STRENGTH	FREQUENCY TAKEN
1.			5.		
2.			6.		
3.			7.		
4.			8.		

ALLERGIES ❒ None Known
Please list all medications and substances to which you are allergic and the type of reaction you have.

_____

_____

SOCIAL HISTORY
Employer and Occupation:_____

Do you drink alcohol? ❒Yes ❒No If yes, what kind and how much? _____

Do you smoke? ❒Yes ❒No If yes, what, and how much? _____

Are you a former smoker? ❒Yes❒No

Do you exercise regularly?❒Yes❒No What type of physical activity do you perform regularly?_____

_____

Do you have someone to assist you at home? ❒Yes ❒No Are you Pregnant? ❒Yes ❒No

NAME: _____ Date of birth: _____
(Please print) Today's date: _____

REVIEW OF SYSTEMS

Place a check mark (✓) if you ever had or have been treated for the following conditions

Constitutional

❒**Dementia**	❒Unusual fatigue	❒Fever (currently)
❒**Alzheimer's**	❒Headaches (currently)	❒Chills (currently)

Cardiovascular (CV)

❒**Blood clot/phlebitis**	❒Palpitations	❒Chest Pain
❒**Heart Attack**	❒Swelling	❒Shortness of breath
❒**Stroke**	❒Pain in legs at rest	❒Pain in legs while moving
❒**Vascular Disease**		
❒**High Blood Pressure**		

Respiratory

❒**Asthma**	❒Wheezing	❒Sleep Apnea

Gastrointestinal (GI)

❒**Ulcer disease**	❒Diarrhea	❒Abdominal pain
	❒Blood in stool	❒Constipation

GU:

❒**STD**	❒Frequent urination	❒Dysuria (painful urination)
❒**Kidney disease**	❒Hematuria (blood in urine)	

Endocrine

❒**Diabetes**	❒Unexplained weight loss or gain
❒**Hyperthyroid**	❒Excessive sweating
❒**Hypothyroid**	❒Excessive thirst

Immunologic

❒**Cancer**	
❒**HIV/AIDS**	❒Latex sensitivity
❒**Hepatitis**	

Hematologic

❒**Anemia**	❒Easy bruising
❒**Von Willebrand's**	❒Easy bleeding

Musculoskeletal (MSK)

❒**Osteoarthritis**	❒Low back pain	❒Stiffness
❒**Rheumatoid Arthritis**	❒Joint pain	❒Weakness
❒**Gout**	❒Muscle pain	

Neurological

❒**Epilepsy/convulsions**	❒Numbness	
❒**Neuropathy**	❒Pins & Needles	❒Muscle wasting

Integumentary

❒**Psoriasis**	❒Dry skin	❒Unusual skin growths on foot
❒**Skin Cancer**	❒Itchy Skin	❒Abnormal scars (Hypertrophic)
	❒Rashes (current)	

Psychiatric

❒**Anxiety**	❒Sleep disturbance	❒Addictions, specify: _____
❒**Depression**	❒Claustrophobia	

❒ Check here if none of the above apply to you.

Please list any other conditions we should know about: _____

NAME: _____ Date of Birth: _____

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Today's Date:_____

PORTLAND FOOT & ANKLE

Patient Name: _____ Medical Rec. #: _____

Date of Birth: _____

General Consent for Treatment
Assignment of Benefits
Patient Responsibility for Payment

I, the undersigned, being either the patient or the patient's legally authorized representative, do hereby:

GENERAL CONSENT FOR TREATMENT

- ✓ Consent to medical treatment and/or evaluation, including but not limited to laboratory and x-ray examinations, and minor in office procedures

ASSIGNMENT OF BENEFITS

- ✓ Assign all benefits under any insurance or health benefit plan for payment for medical services rendered by Drs. Flanigan, Juris, Maisak & Long to Portland Foot and Ankle.

PATIENT RESPONSIBILITY FOR PAYMENT

- ✓ Accept financial responsibility for any amount not paid by insurance or other health benefit plans in accordance with Portland Foot and Ankle's "Patient Financial Policy".

REQUIRED FORMS

I have received a copy of the "Patient Financial Policy / Patient Rights and Responsibilities" and a copy of the Portland Foot and Ankle "Notice of Privacy Practices". I understand that it is my responsibility to read the information, and ask any questions that I may have. I further understand that current copies of both documents will be available at all times for my review.

I understand this document remains in effect for as long as I continue to visit Portland Foot and Ankle, unless specifically rescinded in writing.

Please note that this is not a records release form. If you would like us to share your records with others such as family members, friends, or other health care providers other than your primary care provider, please fill out our Authorization to Disclose Health Information form.

_____ _____
Patient Signature: Date:

_____ _____
Legally Authorized Representative:
(If patient is under the age of 18 or otherwise unable to consent)

For legally Authorized Representative ONLY

Relationship: _____ Reason:

☐ Minor Patient*
☐ Other/POA (copy of legal document(s) required for placement in patient medical record)

*List other authorized person(s) who may accompany or make treatment decisions for the minor patient in the absence of the above representative.

_____ _____
Name Relationship

_____ _____
Name Relationship