

Welcome To Our Office

(PLEASE PRINT AND FILL OUT ALL ITEMS COMPLETELY)

This document will be shredded once the information is entered into the computer system.

Today's Date _____

Patient's Name _____ Date of Birth _____

How would you like our staff to address you/Nickname? _____ Male _____ Female _____

Home Address _____ City _____ State _____ Zip _____

Mailing Address _____ City _____ State _____ Zip _____

Home Phone # (____) _____ Email _____

Social Security # _____ - _____ - _____

Employer _____ Occupation/Section _____

Phone # (____) _____ Length of Employment _____ City/Town _____

Primary Care Physician _____ Date Last Seen _____

Emergency Contact _____ Relationship _____

Home Phone # (____) _____ Work Phone # (____) _____

If the patient is a minor, or living at home, the patient's parents or legal guardian needs to fill out this section.

Responsible Party _____ Relationship to patient _____ Parent _____ Legal Guardian

Social Security # _____ - _____ - _____

Address _____ City _____ State _____ Zip _____

Date of Birth _____ Home Phone # (____) _____

Employer _____ Occupation _____ Length of Employment _____

Phone # (____) _____ City _____ State _____ Zip _____

How did you hear about our office? (Please check appropriate source)

My Doctor Referred Me _____ Insurance Company _____ Family Member _____
(Name of Doctor) (Name)

I have seen Dr. Schultz before _____ Friend _____
(Name)

Our Sign ___ Yellow Pages ___ Our Website ___ Google Search ___ Reporter Herald ___ Loveland Connection ___

Style Magazine ___ Yahoo Search ___ Dex Online Search ___ Radio ___ Speech Forum ___ Other ___

PATIENT MEDICAL HISTORY

Patient's Name: _____ Age: _____

Height: _____ Weight: _____

What condition(s) are you being seen for today? _____

MEDICAL HISTORY: Have you had, or do you currently have any of the following? Please check **all** that apply.

- | | | | |
|---|--|--|---|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Circulatory problems | <input type="checkbox"/> Seizures | <input type="checkbox"/> Cancer _____ |
| <input type="checkbox"/> Hepatitis/Liver problems | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Paralysis | <input type="checkbox"/> Currently pregnant |
| <input type="checkbox"/> Kidney Disease/Renal Failure | <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Neuritis/neuralgia | <input type="checkbox"/> Large weight change |
| <input type="checkbox"/> Hyperthyroid | <input type="checkbox"/> Heart Disease/ Heart attack | <input type="checkbox"/> Neurologic Disorder | <input type="checkbox"/> Weakness/fatigue |
| <input type="checkbox"/> Hypothyroid | <input type="checkbox"/> Bleeding Tendency | <input type="checkbox"/> Numbness | <input type="checkbox"/> Stomach Ulcers |
| <input type="checkbox"/> Swollen glands | <input type="checkbox"/> Blood Transfusion | <input type="checkbox"/> Psychiatric history | <input type="checkbox"/> Digestive problems |
| <input type="checkbox"/> Gout | <input type="checkbox"/> Stroke(CVA) | <input type="checkbox"/> Bipolar Disorder | <input type="checkbox"/> Frequent sore throat |
| <input type="checkbox"/> Rheumatic fever | <input type="checkbox"/> Swelling of feet or ankles | <input type="checkbox"/> Depression | <input type="checkbox"/> Frequent thirst |
| <input type="checkbox"/> Bone/joint disease | <input type="checkbox"/> Slow to heal | <input type="checkbox"/> Frequent anxiety | <input type="checkbox"/> Frequent headaches |
| <input type="checkbox"/> Rheumatoid Arthritis | <input type="checkbox"/> Chest pain | <input type="checkbox"/> COPD | <input type="checkbox"/> Frequent urination |
| <input type="checkbox"/> Osteoarthritis/DJD | <input type="checkbox"/> Leg cramps | <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Skin rashes/conditions |
| <input type="checkbox"/> Swelling of Joints | <input type="checkbox"/> Varicose veins | <input type="checkbox"/> Asthma | <input type="checkbox"/> Chicken Pox |
| <input type="checkbox"/> Back pain | <input type="checkbox"/> Anemia | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Immune system problems |
| | | <input type="checkbox"/> Excessive coughing | <input type="checkbox"/> HIV/AIDS |

Any other problems or conditions **not** listed above: _____

List all previous significant **injuries** and dates (broken bones, sprains, ect) _____

Other doctors you are currently seeing: _____

Have you ever been advised to have a surgical operation which has not been done? _____

Has anyone in your family had a similar foot problem? Who/What _____

HOSPITALIZATION AND SURGICAL HISTORY

List all previous surgeries or hospitalizations and dates: _____

Any problems healing? _____

MEDICATIONS: Please list **ALL** medications you are currently taking

<u>Medication</u>	<u>How Often Taken</u>	<u>Strength</u>	<u>Reason for Taking</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

ALLERGIES

- | | | | |
|---------------------|----------------|--------------------------------------|-----------------------------|
| ___ Aspirin | ___ Penicillin | ___ Sulfa | ___ Other antibiotics _____ |
| ___ Novacaine | ___ Iodine | ___ Codeine | ___ Contrast dyes |
| ___ Tape/ Band-Aids | ___ Metals | ___ Morphine | |
| ___ Latex | ___ Cortisone | ___ Other (food, fabric, etc.) _____ | |

SOCIAL HISTORY (Please circle)

Marital Status: Single ___ Married ___ Widowed ___

Employment: Employed-Part Time ___ Full Time ___ Not Employed ___ Retired ___ Student- Part Time ___ Full Time ___

Use of Alcohol: Never ___ Occasionally ___ Moderate ___ Daily ___ Quantity _____

Smoking: No ___ Previously but quit ___ Yes, Packs per day? _____

Recreational/ Street Drug Use: _____ Never Rarely Daily

Exercise, Sports, or Recreational Activities _____

FAMILY HISTORY

Please list all diseases/conditions common to your family including heart disease, diabetes, rheumatoid diseases, arthritis, and genetic problems.

If deceased, cause of death

Father: _____

Mother: _____

Siblings: _____

Grandparents: _____

I state that the above medical information is true and accurate to the best of my knowledge. I understand that providing incorrect information can be dangerous to my health. I understand it is my responsibility to inform the doctor's office of any changes in my medical status.

Signature of Patient/Parent or Guardian

Date

Insurance Information

Patient's Primary Insurance

Name of Company _____ Policy Holder's Name _____
Group # _____ Policy ID # _____

Patient's Secondary Insurance (If Applicable)

Name of Company _____ Policy Holder's Name _____
Group # _____ Policy ID # _____

Complete this section if someone else is the Primary Policy Holder

Responsible Party _____ Relationship to patient _____
Social Security # _____ - _____ - _____
Address _____ City _____ State _____ Zip _____
Date of Birth _____ Home Phone # (____) _____

Employer _____ Occupation _____ Length of Employment _____
Phone # (____) _____ City _____ State _____ Zip _____

Workers Compensation Claims

Referred By Doctor _____ Date of Accident _____
Employer (at time of accident) _____ Employer's Phone # (____) _____
Claim # _____ Name of Insurance carrier: _____
Adjuster's Name _____ Phone # (____) _____

Our office will file the insurance claims for medical and surgical charges. Self-Pay patients require payment on the date of service. Please remember, you are responsible for all fees, regardless of insurance coverage & all charges if a referral for HMO plans is not obtained prior to date of service.

I authorize the release of any medical information to process insurance claims.

I authorize payment directly to Loveland Foot and Ankle Clinic, P.C. dba Advanced Foot and Ankle Care (AFAC) for medical and/or surgical benefits, if any, otherwise payable to me for the services as described, realizing that I am responsible to pay for non-covered services.

I have reviewed, understand and consent to the Financial Policies of Loveland Foot and Ankle Clinic, P.C. dba AFAC.

Signature of Patient or Legal Guardian _____ Date _____