

WESTFIELD FOOT AND ANKLE, LLC

Patient Information (Please fill out completely)

Date _____

Last name _____ First Name _____ MI _____ Birth Date _____

Address _____ City _____ State _____ Zip _____

Phone # _____ Cell Phone# _____ E-mail _____

SSN _____ Sex: F M Marital Status: S M D W

Race: American Indian or Alaska Native Asian Black or African American Native Hawaiian or Pacific Islander White

Ethnicity: Hispanic or Latino Not Hispanic or Latino Primary Language _____

What type of problem brings you to our office?

Primary Physician _____ Date last seen _____

Emergency contact _____ Phone# _____

Patient Employer _____ Employer's Phone# _____

Address _____ City _____ State _____ Zip _____

Primary Insurance Co. _____ ID# _____ Group# _____

Secondary Insurance Co. _____ ID# _____ Group# _____

Insurance Carrier (person whom subscribes to the insurance) Self

Last name _____ First Name _____ Birth Date _____

Address _____ City _____ State _____ Zip _____

Phone # _____ SSN _____ Employer _____

Request for Confidential Communications:

For written communications: Use address above
 Use email address above only
 Use the following mailing address:

Address _____ City _____ State _____ Zip _____

For oral communications with whom may we leave a message: Patient/parent (if under 18) only
 Patient & spouse only
 Anyone who answers phone

How did you hear about us?

Live nearby/Saw office Friend/Family/Patient Newspaper Phonebook Website/Internet

Physician _____ Other _____

Medications (including vitamins):

Allergies (to medications & foods) and reactions:

Your PARENT's medical history: M=Mother/F=Father

M F Alcoholism

M F Arthritis

M F Seizures

M F Diabetes

M F Cancer

M F Neurological Disorder

M F Anesthesia Problems

M F Heart Problems

PAST MEDICAL HISTORY (please X if you have had these):

Cardiovascular

Congestive Heart Failure

Valve Problems

Low Blood Pressure

Murmur

Stroke

General Cardiovascular Problems

Deep Vein Thrombosis/Blood Clot

High Blood Pressure

Dermatologic

Candidiasis (yeast infection)

Cellulitis

STD

Itchy Dry Skin

Keratosis

Psoriasis

Fungal Infections

Reynaud's Phenomenon

Skin Cancer

Plantar Warts

Other Warts

Endocrine

Diabetes (Type 1 or 2?)

Hypothyroidism

Gastric/Intestinal

Cancer

Colitis

Crohn's

Diverticulitis

GERD

Gastritis

GI Bleed

Liver Conditions

Stomach or Bowel Problems

GU

Bladder dysfunction

Kidney Problems

Dialysis

Hematological

Anemia

Leukemia

Hemophilia

Bleeding abnormalities

Lymphoma

Musculoskeletal

Amputation

Neoplasm

Fracture History _____

Ganglion Cyst

Gout

Arthritis (type) _____

Osteomyelitis

Osteoporosis

Neurological History

Alzheimer's

Sciatica

Multiple Sclerosis

Neuropathy

Seizure Disorder

Psychiatric

Alcoholism

Drug Abuse

Depression

Dementia

REVIEW of SYMPTOMS (recent symptoms only)

Cardiovascular

- | | | | |
|-------------------------------------|------------------------------------|--|--|
| <input type="checkbox"/> arm pain | <input type="checkbox"/> back pain | <input type="checkbox"/> chest pain | <input type="checkbox"/> chest pressure |
| <input type="checkbox"/> cold hands | <input type="checkbox"/> cold feet | <input type="checkbox"/> calf cramping | <input type="checkbox"/> high blood pressure |

Constitutional Symptoms

- | | | | |
|---------------------------------|------------------------------------|-----------------------------------|---------------------------------|
| <input type="checkbox"/> fever | <input type="checkbox"/> dizziness | <input type="checkbox"/> diarrhea | <input type="checkbox"/> chills |
| <input type="checkbox"/> nausea | <input type="checkbox"/> vomiting | | |

Endocrine

- | | | |
|---|-----------------------------------|---|
| <input type="checkbox"/> cold intolerance | <input type="checkbox"/> dry eyes | <input type="checkbox"/> weight changes |
|---|-----------------------------------|---|

Gastrointestinal

- | | | |
|---|------------------------------------|---|
| <input type="checkbox"/> abdominal pain | <input type="checkbox"/> heartburn | <input type="checkbox"/> blood in stool |
|---|------------------------------------|---|

Hematologic/Lymphatic

- | | | | |
|---|------------------------------------|--|--|
| <input type="checkbox"/> ankle/foot edema | <input type="checkbox"/> calf pain | <input type="checkbox"/> bruise easily | <input type="checkbox"/> bleeding problems |
|---|------------------------------------|--|--|

Integumentary

- | | | | |
|--|---|-------------------------------|---------------------------------------|
| <input type="checkbox"/> athlete's foot | <input type="checkbox"/> discoloration | <input type="checkbox"/> cyst | <input type="checkbox"/> leg swelling |
| <input type="checkbox"/> dry, scaly skin | <input type="checkbox"/> lower leg ulcers | | |

Musculoskeletal

- | | | | |
|------------------------------------|---|-------------------------------------|--------------------------------------|
| <input type="checkbox"/> back pain | <input type="checkbox"/> joint swelling | <input type="checkbox"/> foot pain | <input type="checkbox"/> muscle pain |
| <input type="checkbox"/> hip pain | <input type="checkbox"/> neck pain | <input type="checkbox"/> joint pain | <input type="checkbox"/> stiffness |

Neurological

- | | | | |
|------------------------------------|------------------------------------|------------------------------------|-----------------------------------|
| <input type="checkbox"/> dizziness | <input type="checkbox"/> migraines | <input type="checkbox"/> confusion | <input type="checkbox"/> seizures |
| <input type="checkbox"/> tingling | <input type="checkbox"/> headache | <input type="checkbox"/> tremors | |

Respiratory

- | | | | |
|---|-------------------------------------|--|--|
| <input type="checkbox"/> difficulty breathing | <input type="checkbox"/> chest pain | <input type="checkbox"/> chest tightness | <input type="checkbox"/> shortness of breath |
|---|-------------------------------------|--|--|

Past Surgical History (TYPE of surgery & YEAR surgery was performed)

Social History

Do you smoke? Yes No How much _____ for how long _____

Do you drink alcohol? Yes No How much _____ for how long _____

How often do you exercise? _____ What type of exercise? _____

What type of activity do you do at work (mostly sitting, standing, both)? _____

PRIMARY & SUPPLEMENTAL INSURANCE

I hereby authorize the release of any information necessary to file a claim with the insurance company and assign benefits to Westfield Foot & Ankle, LLC doctors and staff. This includes any coverage under Medigap.

For patients with Medicare: Medicare makes payments only after a yearly deductible has been satisfied. For patients with both Medicare and Medicaid: Medicaid does not pay the Medicare annual deductible amount, this will be billed to the patient or responsible party.

For patients with Preferred Senior Care: Preferred Senior Care is not expected to pay for this service. Patient or responsible party agrees to pay all charges not covered by Medicare, Medicaid, Medigap, VA, or other insurance.

Failure to pay charges is agreed to imply discontinuation of podiatry service.

Signature: _____ Date: _____

**ACKNOWLEDGEMENT of RECEIPT of
NOTICE of PRIVACY PRACTICES**

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read if I so chose) and understand the Notice.

Patient Name (please print)

Date

Parent or Authorize Representative (if applicable)

Signature