LEGAL NOTICE/DISCLAIMER

The information contained in this document does not establish a standard of care, nor does it constitute legal advice. The information is for general informational purposes only and is written from a risk management perspective to aid in reducing professional liability exposure. Please review this document for applicability to your specific practice. You are encouraged to consult with your personal attorney for legal advice, as specific legal requirements may vary from state to state.

NATIONAL CAPITAL FOOT & ANKLE CENTER

PATIENT INFORMATION FORM

(PLEASE PRINT)

DATE: ___/____/____

PATIENT NAME: _____ _____ ___ DATE OF BIRTH: ___/___/___ AGE: ___ SEX: M F
LAST FIRST MI

HOME ADDRESS: _____ CITY/STATE: _____ ZIP: _____

MAY WE LEAVE A MESSAGE?

HOME PHONE #: (____) ____-_____ YES NO

WORK PHONE #: (____) ____-_____ YES NO

CELL PHONE #: (____) ____-_____ YES NO

E-MAIL: _____ YES NO

PRIMARY LANGUAGE: _____

DO YOU HAVE A LEGAL GUARDIAN OR HEALTHCARE POWER OF ATTORNEY? YES NO

IF YES, NAME: _____ RELATIONSHIP: _____ PHONE #: (____) ____-_____

EMERGENCY CONTACT: _____ RELATIONSHIP: _____ PHONE #: (____) ____-_____

PRIMARY CARE DOCTOR: _____ PHONE: _____

PHARMACY: _____ LOCATION: _____ PHONE #: (____) ____-_____

IS THERE A FAMILY MEMBER OR OTHER PERSON YOU WOULD LIKE FOR US TO SHARE YOUR MEDICAL INFORMATION?

_____ YES NAME(S) _____

_____ NO

WHO IS RESPONSIBLE FOR PAYMENT? _____ RELATIONSHIP TO PATIENT? _____

ADDRESS: _____ CITY/STATE: _____ ZIP: _____ PHONE #: (____) ____-_____

WHO REFERRED YOU TO US?_____

INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY NAME: _____

~~IN~~SURED NAME: _____ DATE OF BIRTH _____ EMPLOYER _____

CONTRACT # _____ GROUP # _____ RELATIONSHIP TO INSURED _____ SEX M F

SECONDARY INSURANCE COMPANY NAME: _____

INSURED NAME: _____ DATE OF BIRTH _____ EMPLOYER _____

CONTRACT # _____ GROUP # _____ RELATIONSHIP TO INSURED _____ SEX M F

Revised April 2013

Please list all medications you are currently taking (Include prescriptions, over-the-counter meds and herbal supplements):

Name	Dose	How often do you take?

Please list all prior surgeries:

Type of Surgery	Date	Type of Surgery	Date

Please list all prior hospitalizations (other than for surgery):

Reason For Hospitalization	Date	Reason For Hospitalization	Date

Social History

Marital Status: ☐ Single ☐ Married ☐ Partnered ☐ Separated ☐ Divorced ☐ Widowed

Use of Alcohol: ☐ Never ☐ No longer use ☐ History of alcohol abuse
☐ Current USE - Type _____ ☐ Rare ☐ Occasional ☐ Moderate ☐ Daily

Use of Tobacco: ☐ Never ☐ Quit – how long ago? _____ ☐ Smoke ___ packs/day for ___ years

Use of Recreational Drugs: ☐ Never ☐ Quit – How long ago? _____ Type _____
☐ Current USE - Type _____ ☐ Rare ☐ Occasional ☐ Moderate ☐ Daily

Employer: _____ Occupation: _____

How much are you on your feet at work? ☐ 10% ☐ 25% ☐ 50% ☐ 75% ☐ 100%

Do others depend upon you for their care? ☐ Children–age(s) _____ ☐ Pet(s)–what kind? _____
☐ Elderly or disabled family member ☐ Other _____

Exercise: ☐ Never ☐ Rare ☐ Occasional ☐ weekly ☐ Several times a week ☐ Daily

Types of exercise: _____

Family History

Do you have a family history of: ☐ Diabetes ☐ Cancer ☐ Heart Disease ☐ High Blood Pressure
☐ Stroke ☐ Coronary Artery Disease ☐ Thyroid Disease ☐ Rheumatoid Arthritis
☐ Other _____

Your Medical History

ALLERGIES: ☐ MEDICATIONS _____
☐ ANESTHESIA _____ ☐ FOODS _____
☐ TAPE ☐ LATEX ☐ SHELLFISH ☐ IODINE ☐ OTHER _____
☐ NONE KNOWN

HAVE YOU EVER HAD ANY OF THE FOLLOWING?

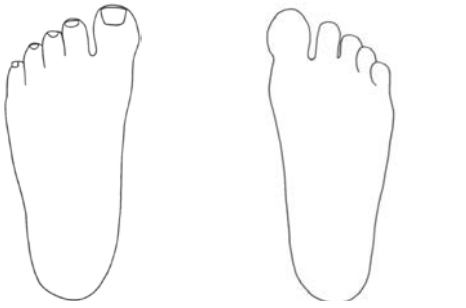
ACID REFLUX	Y	N	FIBROMYALGIA	Y	N		NEUROPATHY	Y	N
ANEMIA	Y	N	GOUT	Y	N		OPEN SORES	Y	N
ARTHRITIS	Y	N	HEART ATTACK	Y	N		PNEUMONIA	Y	N
ASTHMA	Y	N	HEART DISEASE/FAILURE	Y	N		POLIO	Y	N
BACK TROUBLE	Y	N	HEPATITIS	Y	N		RHEUMATIC FEVER	Y	N
BLADDER INFECTIONS	Y	N	HIV+/AIDS	Y	N		SICKLE CELL DISEASE	Y	N
ABNORMAL BLEEDING	Y	N	HIGH BLOOD PRESSURE	Y	N		SKIN DISORDER	Y	N
BLOOD CLOTS	Y	N	KIDNEY DISEASE	Y	N		SLEEP APNEA	Y	N
BLOOD TRANSFUSION	Y	N	LIVER DISEASE	Y	N		STOMACH ULCERS	Y	N
BRONCHITIS/EMPHYSEMA	Y	N	LOW BLOOD PRESSURE	Y	N		STROKE	Y	N
CANCER	Y	N	MIGRAINE HEADACHES	Y	N		THYROID DISEASE	Y	N
DIABETES	Y	N	MITRAL VALVE PROLAPSE	Y	N		TUBERCULOSIS	Y	N
OTHER CONDITIONS:									

CURRENT PROBLEM

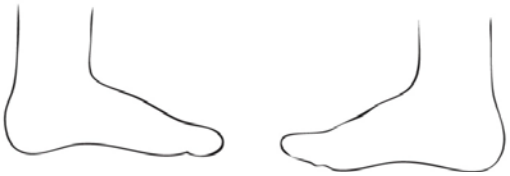
WHAT SPECIFIC PROBLEM BRINGS YOU TO OUR OFFICE TODAY? _____

WHERE IS THE PAIN/PROBLEM LOCATED? PLEASE MARK ON THE PICTURES BELOW.

LEFT FOOT

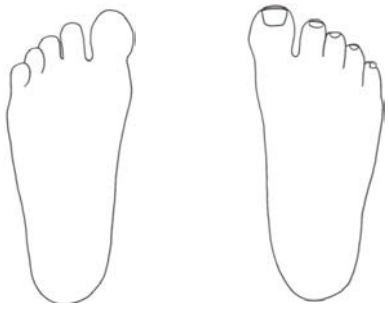


TOP OF FOOT BOTTOM OF FOOT



INSIDE OF FOOT OUTSIDE OF FOOT

RIGHT FOOT



BOTTOM OF FOOT TOP OF FOOT

OUTSIDE OF FOOT INSIDE OF FOOT

How long ago did this problem first start? _____ Days / Weeks / Months / Years

Did your pain or problem: ☐ Begin all of a sudden ☐ Gradually develop over time

How would you describe your pain? ☐ No pain ☐ Sharp ☐ Dull ☐ Aching ☐ Burning
☐ Radiating ☐ Itching ☐ Stabbing ☐ Other _____

How would you rate your pain on a scale from 0 to 10? (please circle)
(no pain) 0 1 2 3 4 5 6 7 8 9 10 *(worst pain possible)*

Since the time your pain or problem began, has it: ☐ stayed the same ☐ become worse ☐ Improved

What makes your pain or problem feel worse? ☐ Walking ☐ Standing ☐ Daily activities
☐ Resting ☐ Dress shoes ☐ High heels ☐ Flat shoes ☐ Any closed toe shoe
☐ Running ☐ Other _____

What makes your pain or problem feel better? _____

What treatments have you had for this problem? _____

How has this problem affected your lifestyle or ability to work? _____

Was this problem caused by an injury? ☐ Yes (describe) _____ ☐ No

If yes, was it a work-related injury? ☐ Yes ☐ No

Formatted: Border: Bottom: (Double solid lines, Auto, 1.5 pt Line width, From text: 2 pt Border spacing:)

If you have, United Healthcare/PPO/POS/OA/HMO, One-Net, Carefirst Indemnity/PPO/Blue Choice, Cigna PPO/Choice Plus, Great West, One Health, Aetna PPO/POS/HMO or PHCS/Multi-Plan, we will submit to you insurance company. Your copay is due at the times services are rendered. We will submit to your insurance carrier when given all the necessary information to process you insurance claim (i.e., full name of insured, date of birth, social security number, copy of state issued identification card, copy of insurance card and authorization number/referral if necessary. If you cannot provide us with this necessary information, you are assuming financial responsibility for you medical care. Payment is due when services are rendered.

I understand that I am financially responsible for all charges rendered to me, regardless of any insurance billing. This includes balance remaining after payment of possible insurance benefits, copays and deductibles. Accounts over 60 days old are subject to 1.5% finance charge per month, rebilling charges, and collection fees. I authorize payment of insurance benefits directly to Dr. Polun. I authorize the release of any medical information necessary to process my insurance claims. **Please note that there will be a $25 fee for an appointment that is not cancelled within 24 hours of a missed appointment**. Further, I understand that I can be billed for any insurance claim left unpaid by my carrier after 60 days. By signing below, I agree to the terms of Dr. Polun's office policy. If unsigned, no treatment will be render to me. This policy will be enforced **UNLESS PRIOR ARRANGEMENTS HAVE BEEN MADE WITH DR. POLUN OR THE OFFICE MANAGER.** Thank you in advance for accepting or policy.

_____ _____
Print name of patient, parent or guardian Signature of doctor

_____ _____
If other than patient, relationship to patient Date

_____
Signature

Revised April 2013

DATE

Revised April 2013