

PIONEER FOOT AND ANKLE - New Patient Form

Please Print

Last Name: _____ First Name: _____ MI: _____

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

Home # () _____ Cell # () _____ Work # () _____

Emergency Contact: _____ Phone: () _____ Relationship: _____

E-Mail: _____

Family Physician: _____ Phone Number: () _____

Fax Number: () _____

Birth Date: ____/____/____ Marital Status: Single Married Widowed Divorced

Employer: _____ Employer Address: _____

__ FULL TIME __ PART TIME __ NOT EMPLOYED __ SELF-EMPLOYED __ RETIRED __ ACTIVE MILITARY DUTY __ STUDENT

Pharmacy: _____ Pharmacy Phone Number: () _____

HOW DID YOU HEAR ABOUT US: Doctor Referral Insurance Friend/Family Internet/Google

Referred by: _____ Other: _____

RELEASE OF PERSONAL INFORMATION TO THE PATIENT'S DESIGNEES

I authorized medical staff members of this practice to discuss my medical history, diagnosis, treatment and prognosis with other medical providers and organizations that participate in care and with those listed below.

Name	Phone Number	Relationship
_____	_____	_____
_____	_____	_____

ASSIGNMENT OF INSURANCE BENEFITS

The undersigned hereby authorizes the release of any information relating to all claims for benefits submitted on behalf of myself and/or my dependents. I further expressly agree and acknowledge that my signature on this document authorizes my physician to submit claims for benefits and services rendered, without obtaining my signature on each and every claim to be submitted for myself and/or my dependents. I will be bound by this signature as though the undersigned had personally signed the particular claim.

I, _____, hereby authorize _____ to pay and hereby assign directly to PIONEER FOOT AND ANKLE all benefits. I further acknowledge that any insurance benefits, when received by and paid to PIONEER FOOT AND ANKLE will be credited to my account in accordance with the above said assignment.

Agreed & Authorized: _____ **Date:** _____

SOCIAL HISTORY

Do or Did you smoke cigarettes? Yes No If Yes, packs per day? _____ Stop date: _____

Drink alcohol regularly? Yes No Do you exercise regularly? Yes No

Allergies to any medication? Yes No If Yes, which medications? _____

Place of Birth? _____ Unusual Occupational Exposures? _____

Please list ALL medications you are currently taking: _____

MEDICAL HISTORY:

Previous Surgery/Hospitalizations _____

Blood Transfusions (dates): _____ General Anesthesia: _____

Injuries and Fractures (types & dates): _____

FAMILY HISTORY (check if anyone in your family has had or had the following)

	MOTHER	FATHER	SILBINGS	CHILDREN	OTHER RELATIVE
CANCER					
DIABETES					
HEART DISEASE					
ARTHRITIS					
OSTEOPOROSIS					
AGE (IF LIVING)					

SYSTEMIC REVIEW (DO YOU NOW HAVE OR EVER HAD THE FOLLOWING)

	YES	NO		YES	NO
Chronic Headaches/Migraines			Diabetes		
Dizziness			High Blood Pressure		
Fainting Spells/Blackouts			High Cholesterol		
Eye Disease/Glaucoma/Cataracts			Joint Pains/Swelling		
Double Vision			Swelling of ___ Feet ___ Ankles		
Recent Vision Impairment			Numbness/Tingling of hand/Feet		
Impaired Hearing			Color Changes in the Hands		
Ringing in the Ears			Chest Pressure/Chest Pain		
Dryness of ___ Eyes ___ Mouth			Chronic Back Pain		
Recent Hair Loss			Chronic Neck Pain		
Asthma			Parkinsonism		
Recurrent Fever			Osteoporosis		
Thyroid Disorder			Sciatica		
Pneumonia			Anemia or Blood Disorder		
Pleurisy			Skin Rash		
Frequent Cough			Psoriasis		
Tuberculosis Exposure			Recent Weight ___ Gain ___ Loss		
Difficulty Breathing			Loss of Appetite		
Coughing Up Blood			Constant Thirst or Hunger		
Rheumatic Fever			Stomach/Duodenal Ulcer		
Difficulty Urinating			Abdominal Pain/Heart Burn		
Painful/frequent Urination			Frequent Nausea/Vomiting		
Blood in Urine			Heart Murmur		
Nighttime Urination ___ Times			Cancer		
Prostate Disorder			Palpitations		
Recurring Bladder Infections			Convulsions OR Epilepsy		
Kidney Disease/Stones			Hepatitis/Jaundice		
Pancreatitis			HIV Virus Positive		
Diverticulitis			Chronic Anxiety		
Phlebitis			Depression		
Insomnia					

Date of: Most Recent Medical Exam _____

EKG _____ Blood Tests _____ Chest X-Ray _____

Reason for office visit today: _____

NOTICE OF PRIVACY PRACTICE ACKNOWLEDGMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1998 (“HIPAA”), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I acknowledge that I have received your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name _____

Relationship to Patient _____

Signature _____

Date _____

OFFICE USE ONLY

I attempted to obtain the patient’s signature in acknowledgment on the Notice of Privacy Practices Acknowledgment, but was unable to do so as documented below:

Date: _____ Initials: _____ Reason: _____