PATIENT HISTORY

Today's Date: _____

Name: _____

Date of Birth: _____ Age: _____ Height: _____ Weight: _____

Reason for today's appointment:

_____

_____

Please List All Prescription and Over the Counter (OTC) Medications (Drug Name and Dosage)

_____

_____

_____

Please List Any Allergies You May Have: ☐ No Known Drug Allergy

☐ Aspirin ☐ Betadine/Iodine ☐ Codeine ☐ IVP Dye ☐ Morphine ☐ Penicillin ☐ Sulfa

☐ Anesthetics/Lidocaine/Novocain ☐ Anti-Inflammatories ☐ Cortisone ☐ Latex

☐ Other _____ ☐ Other _____ ☐ Other _____

Have you or a family member ever had any problems with anesthesia? ☐ Yes ☐ No

Social History:

Do you smoke? ☐ Yes ☐ No How many packs per day? _____ How many years? _____

Have you ever smoked? ☐ Yes ☐ No When did you quit? _____

Do you drink alcohol? _____ How often? _____

Have you ever used recreational drugs? _____ Have you abused prescription medications? _____

Family History:

Do any diseases run in your family?

☐ Arthritis ☐ Bleeding Problems ☐ Cancer Type: _____

☐ High Cholesterol/Triglycerides ☐ Diabetes Type I II ☐ High Blood Pressure ☐ Heart Problems

☐ Sickle Cell ☐ Mental Illness Other: _____

Mother: ____ Alive ____ Deceased Cause of Death: _____

Father: ____ Alive ____ Deceased Cause of Death: _____

Sisters: ____ Alive ____ Deceased Cause of Death: _____

Brothers: ____ Alive ____ Deceased Cause of Death: _____

Past Medical History/Review of Systems:

Do you have any problems with your Heart and/or Circulation?

☐ Chest Pain/Angina ☐ Leg Cramps ☐ Angioplasty or Bypass ☐ Heart Attack ☐ Varicose Veins

☐ High Blood Pressure ☐ Vein Stripping ☐ Stress Test ☐ Congestive Heart Failure ☐ Ulcers

☐ Stents ☐ Pacemaker ☐ Irregular Heart Beat ☐ Ablation

Other: _____

Do you have any problems with your Eyes, Ears, Nose or Throat?

□ Wear Glasses □ Snoring □ Sleep Apnea □Speech Problems □ Nose Bleeds □ Cpap □BIPAP □ Glaucoma □Hearing Aides □ Retinopathy □ Difficulty Swallowing □ Sore Throat □ Blurred Vision □ Hearing Loss □ Ringing of Ears □Macular Degeneration Other: _____

Do you have any problems with your Lungs?

□ COPD □ Bronchitis □ Tuberculosis □ Asthma □ Fluid in Lungs? □ Emphysema □ Pneumonia □ Shortness of Breath Other: _____

Do you have problems with your Liver?

□ Cirrhosis □ Hepatitis □ Jaundice □ Gall Bladder □ Sickle Cell Other: _____

Do you have problems with your Stomach or Bowels?

□ Ulcers □ Colitis □ Polyps □ Reflux □ Hemorrhoids □Crohn's Disease □Difficulty Swallowing □ Indigestion □ Blood in Stool □Hernia □ Diarrhea □ Irritable Bowel □ Constipation
Other: _____

Do you have Musculoskeletal problems?

□Ankle Pain □ Arch Pain □ Arthritis □Bunions □Fractures □Hammertoes □ Herniated Disc □ Bursitis □ Low Back Pain □ Shoulder Pain □Knee Pain □ Hip Pain □ Paresis/Paralysis □ Muscle Weakness Other: _____

Do you have problems with your Skin?

□ Rashes □ Dryness □ Scaliness □ Herpes □ Psoriasis □ Fungal Infection □ Bacterial Infection □ Squamous Cell Carcinoma □ Basal Cell Carcinoma □ Shingles □ Acne □ Itching
Other: _____

Do you have any Neurological problems?

□ Numbness □ Tingling □ Alzheimer's □ Parkinson's Disease □ TIA □ Stroke □ Epilepsy □ Blurred Vision □Weakness □ Burning □ Dementia □ Under the care of Psychologist/Psychiatrist
Other: _____

Do you have any General Medical Problems?

□ Diabetes □ Type 1 □ Type 2 Last Hemoglobin AIC result _____
□ High Cholesterol/Triglycerides □ Cushing's Disease □ Thyroid Disease □ Dialysis □ Adrenal Gland □ Gout □ Dementia □ Rheumatoid Arthritis □ Pituitary Gland
Other: _____

Do you have any problems with your Blood or History of Blood Infections?

□ HIV (AIDS) □ Hepatitis □ Nose Bleeds □ Anemia □ Hemophilia □ Thrombocytopenia □ Leukopenia □ Sickle Cell or Trait Other: _____

Do you have any problems with your Immune System or Allergies?

□ Allergy Shots □ Autoimmune Disease Other: _____

Please SPECIFY your Surgical History

□ Orthopedic:_____ □ Heart:_____ □ Vascular:_____ □ Appendix □ Joint Replacement:_____ □ Intestinal □ Gallbladder □ Implants:_____ □Pregnancy □Hysterectomy/D&C □ Tonsils
□ Other Please Specify:_____

Pharmacy:_____ **Phone Number**_____

Address:_____

_____ _____

Print Name Signature

MERRITT ISLAND FOOT AND ANKLE, INC.

2404 N. Courtenay Pkwy., Merritt Island, FL 32953
6549 N Wickham Rd., E103, Melbourne, FL 32940

PATIENT INFORMATION

(Please Print)

Our physicians, along with their staff would like to welcome you to this office. It is our priority to improve quality of life through treatment of foot and ankle conditions. We are committed to a relationship built on care, compassion, and trust. Please assist us in answering the following questions.

Today's Date: _____

First Name: _____ MI _____ Last Name: _____

Address: _____ Apt: _____

City: _____ State: _____ Zip Code: _____

E-mail: _____

Home Phone: _____ Cell: _____ Work: _____

Date of Birth _____ SSN: _____

Sex: □ Male □ Female Marital Status: □S □M □D □W

Employer: _____ Occupation: _____

In case of an emergency, who should be notified?

Name: _____ Relationship: _____

Address/Telephone: _____

How did you hear about us? _____

Who can we thank for the referral? _____

PRIMARY CARE DOCTOR

Name: _____ **City/State:** _____

Telephone: _____ **Reason for visit:** _____

Tel: (321) 452-1327 Fax: (321) 454-9208

www.brevardfootdoctor.com

MERRITT ISLAND FOOT AND ANKLE, INC.

2404 N. Courtenay Pkwy., Merritt Island, FL 32953
6549 N. Wickham Rd., Suite E103, Melbourne, FL 32940

Dear Patient,

We ask that you please read and sign this form as it concerns you, the patient.

Due to the many changes in insurance policies, it is no longer an easy task to interpret each individual policy, therefore we ask you, the patient to please check with your insurance company regarding your coverage and benefits. It is **YOUR** responsibility to know **YOUR** individual coverage, limitations and coordination of benefits. Failure to comply with this suggestion could result in you, the patient, being responsible for all costs incurred. **Please remember that your insurance policy is between you and your health insurance company.**

If you need a referral/authorization from your insurance company or from your primary care physician (PCP) or from another doctor to be seen in this office, the referral/authorization must be present at the time of your visit. If it is not available, it will be your responsibility to obtain one. Consequently, you will need to reschedule your visit should the referral/authorization not be available. We welcome you to call your insurance company and/or physician and have your referral/authorization faxed to us at (321) 454-9208.

If you have a co-payment or co-insurance, out of pocket expenses, deductibles, services/products not covered by insurance, etc., it must be paid at the time of service.

Please call your insurance company and learn about your coverage. It may save you a lot of confusion and out of pocket expenses.

Print Name: Patient / Parent _____ Date _____ Patient / Parent Signature

Tel: (321) 452-1327 Fax: (321) 454-9208

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AUTHORIZATION FOR TREATMENT/FINANCIAL AGREEMENT/RELEASE OF INFORMATION

I, the undersigned, knowing the patient, minor, and or self, certify that the information above is true and correct to the best of my knowledge. I give permission to the physician and staff to administer and perform diagnostic and therapeutic procedures, including, but not limited to injections, as may be deemed necessary in the diagnosis and/or treatment of lower extremity. I understand that no guarantee has been made as to the result of the procedure/treatment. I authorize release of medical information to my doctor, health agency, insurance company, government agency, or worker's compensation. I request and authorize payment of insurance benefits and/or government benefits made on my behalf to be paid directly to Merritt Island Foot and Ankle, Inc. I assume full financial responsibility for all services rendered, even if I have insurance, and agree to pay if not paid or covered by my insurance within 90 days. It is my responsibility to obtain authorization from my Primary Care Physician or insurance company (if required) prior to services rendered.

_____ _____

Print Name Signature

AUTHORIZATION TO LEAVE MESSAGES

I, the undersigned, give Merritt Island Foot and Ankle permission to leave clinical and/or appointment information on the voicemail or answering machine of the phone numbers I have provided on these forms.

_____ _____

Print Name Signature

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Notice to Patient:

We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the Notice. You may refuse to sign this acknowledgement, if you wish.

I acknowledge that I have received a copy of this office's Notice of Privacy Practices.

_____

Please print your name here

_____

Signature

_____

Date

We cannot discuss your protected health information (PHI) with anyone other than yourself unless you authorize us to do so. Please list below names(s) of the individual(s) you authorize our office to discuss care with. Your PHI may be disclosed to the individual(s) listed below until you notify us otherwise in writing.

Name of Person: Relationship:

_____ _____

_____ _____