

PATIENT NAME: _____
AGE: _____

INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY NAME:

INSURED NAME: _____ DATE OF BIRTH _____ SOC SEC # _____

SECONDARY INSURANCE COMPANY NAME:

INSURED NAME: _____ DATE OF BIRTH _____ SOC SEC # _____

YOUR MEDICAL HISTORY

ARE YOU DIABETIC? _____ **LAST BLOOD SUGAR: DATE** _____ **AMOUNT:** _____

HAVE YOU RECEIVED A FLU VACCINATION FOR THE CURRENT SEASON? YES _____ NO _____

IF NO, WHAT WAS THE REASON? _____ PATIENT ALLERGY _____ PATIENT DECLINE _____ VACCINE UNAVAILABLE

HAVE YOU HAD A PNEUMONIA VACCINATION? YES _____ NO _____

IF OVER THE AGE OF 65, DO YOU HAVE A LIVING WILL OR SOMEONE TO MAKE DECISIONS ON YOUR BEHALF? YES _____ NO _____
IF NO, PLEASE EXPLAIN WHY? _____

DO YOU RECEIVE HOME HEALTH? _____ ARE YOU ENROLLED IN HOSPICE? _____

PLEASE LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING
(INCLUDE PRESCRIPTIONS, OVER-THE-COUNTER MEDS AND HERBAL SUPPLEMENTS)

CURRENT MEDICATIONS

ARE YOU TAKING A BLOOD THINNER? YES, WHICH ONE? _____ NO

NO KNOWN MEDICATIONS

I TAKE THE FOLLOWING MEDICATIONS:

NAME, STRENGTH AND DOSAGE: _____

NAME, STRENGTH AND DOSAGE: _____

NAME, STRENGTH AND DOSAGE: _____

NAME, STRENGTH AND DOSAGE: _____

NAME, STRENGTH AND DOSAGE: _____

NAME, STRENGTH AND DOSAGE: _____

NAME, STRENGTH AND DOSAGE: _____

NAME, STRENGTH AND DOSAGE: _____

NAME, STRENGTH AND DOSAGE: _____

NAME, STRENGTH AND DOSAGE: _____

NAME, STRENGTH AND DOSAGE: _____

PLEASE HAND LIST TO THE FRONT DESK STAFF IF YOU HAVE ONE OR
USE THE BACK OF THIS FORM IF ADDITIONAL ROOM IS NEEDED.

PATIENT NAME: _____

AGE: _____

YOUR MEDICAL HISTORY (CONT.)

ALLERGIES

NAME: _____ REACTION: _____

NAME: _____ REACTION: _____

NAME: _____ REACTION: _____

NAME: _____ REACTION: _____

NAME: _____ REACTION: _____

NAME: _____ REACTION: _____

NAME: _____ REACTION: _____

FOODS _____ TAPE LATEX SHELLFISH IODINE ANESTHESIA

NO KNOWN ALLERGIES

PLEASE HAND LIST TO THE FRONT DESK STAFF IF YOU HAVE ONE OR
USE THE BACK OF THIS FORM IF ADDITIONAL ROOM IS NEEDED.

PLEASE LIST ALL PRIOR SURGERIES:

TYPE OF SURGERY

DATE

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:								

PATIENT NAME: _____

AGE: _____

REVIEW OF SYSTEMS (PLEASE CHECK THE BOX IF YOU CURRENTLY HAVE ANY OF THESE SYMPTOMS OR CHECK "NONE")

CARDIOVASCULAR	<input type="checkbox"/> LEG PAIN WHEN WALKING <input type="checkbox"/> FEVER <input type="checkbox"/> CHEST PAIN/ PRESSURE <input type="checkbox"/> LEG SWELLING <input type="checkbox"/> COLD HANDS/ FEET <input type="checkbox"/> FAINTING <input type="checkbox"/> PALPITATIONS <input type="checkbox"/> VASCULAR DISEASE <input type="checkbox"/> VALVE PROBLEMS <input type="checkbox"/> ELEVATED BLOOD PRESSURE <input type="checkbox"/> HYPERLIPIDEMIA <input type="checkbox"/> NONE
GENITOURINARY	<input type="checkbox"/> BLOOD IN URINE <input type="checkbox"/> HESITANCY <input type="checkbox"/> INCONTINENCE <input type="checkbox"/> INCREASED URGENCY <input type="checkbox"/> DECREASED FREQUENCY <input type="checkbox"/> EXCESSIVE URINATION <input type="checkbox"/> KIDNEY DISEASE <input type="checkbox"/> KIDNEY STONES <input type="checkbox"/> HRT (HORMONE REPLACEMENT THERAPY) <input type="checkbox"/> NONE
GASTROINTESTINAL	<input type="checkbox"/> ABDOMINAL PAIN <input type="checkbox"/> HEARTBURN <input type="checkbox"/> BLOOD IN STOOL <input type="checkbox"/> VOMITING <input type="checkbox"/> ULCERS <input type="checkbox"/> CONSTIPATION <input type="checkbox"/> DIARRHEA <input type="checkbox"/> TROUBLE SWALLOWING <input type="checkbox"/> DECREASED APPETITE <input type="checkbox"/> INCREASED APPETITE <input type="checkbox"/> NONE
INTEGUMENTARY	<input type="checkbox"/> ATHLETES FOOT <input type="checkbox"/> NAIL ABNORMALITIES <input type="checkbox"/> KELOIDS <input type="checkbox"/> ITCHINESS <input type="checkbox"/> DRY, SCALY SKIN <input type="checkbox"/> NONE
HEMATOLOGIC	<input type="checkbox"/> LOWER LEG ULCERS <input type="checkbox"/> SICKLE CELL DISEASE <input type="checkbox"/> ANEMIA <input type="checkbox"/> BLOOD THINNERS <input type="checkbox"/> CLOTTING DISORDERS <input type="checkbox"/> NONE
NEUROLOGICAL	<input type="checkbox"/> TINGLING <input type="checkbox"/> WEAKNESS <input type="checkbox"/> SEIZURES <input type="checkbox"/> NUMBNESS <input type="checkbox"/> HEADACHES <input type="checkbox"/> TREMORS <input type="checkbox"/> PARALYSIS <input type="checkbox"/> NONE
MUSCULOSKELETAL	<input type="checkbox"/> BACK PAIN <input type="checkbox"/> JOINT SWELLING <input type="checkbox"/> MUSCLE WEAKNESS <input type="checkbox"/> MUSCLE PAIN <input type="checkbox"/> NECK PAIN <input type="checkbox"/> SCIATICA <input type="checkbox"/> JOINT STIFFNESS <input type="checkbox"/> JOINT PAIN <input type="checkbox"/> JOINT INSTABILITY <input type="checkbox"/> ARTHRITIS <input type="checkbox"/> NONE
RESPIRATORY	<input type="checkbox"/> CHEST PAIN <input type="checkbox"/> WHEEZING <input type="checkbox"/> COPD <input type="checkbox"/> COUGHING <input type="checkbox"/> SNORING <input type="checkbox"/> SHORTNESS OF BREATH <input type="checkbox"/> EMPHYSEMA <input type="checkbox"/> BREATHING DIFFICULTIES <input type="checkbox"/> NONE

FAMILY HISTORY

FAMILY HISTORY	IS THERE ANY FAMILY HISTORY (BLOOD RELATIVE) OF: (PLEASE INDICATE FAMILY MEMBER)
<input type="checkbox"/> CANCER	_____
<input type="checkbox"/> CORONARY ARTERY DISEASE	_____
<input type="checkbox"/> DIABETES	_____
<input type="checkbox"/> HEART DISEASE	_____
<input type="checkbox"/> HIGH BLOOD PRESSURE	_____
<input type="checkbox"/> RHEUMATOID ARTHRITIS	_____
<input type="checkbox"/> STROKE	_____
<input type="checkbox"/> THYROID DISEASE	_____
<input type="checkbox"/> OTHER (PLEASE SPECIFY)	_____

SOCIAL HISTORY

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

HOW MUCH ARE YOU ON YOUR FEET? 10% 25% 50% 75% 100%

EXERCISE: NEVER OCCASIONAL WEEKLY SEVERAL TIMES A WEEK DAILY

TYPES OF EXERCISE/LEISURE ACTIVITIES: _____

PATIENT NAME: _____

AGE: _____

CURRENT PROBLEM

WHAT SPECIFIC PROBLEM BRINGS YOU TO OUR OFFICE TODAY? _____

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 (CHECK ALL THAT APPLY)? 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) _____ DATE _____ NO

IF YES, WAS IT A WORK-RELATED INJURY? YES NO

TO THE BEST OF MY KNOWLEDGE, I HAVE ANSWERED THE QUESTIONS ON THIS FORM ACCURATELY. I UNDERSTAND THAT PROVIDING INCORRECT INFORMATION CAN BE DANGEROUS TO MY HEALTH. I UNDERSTAND THAT IT IS MY RESPONSIBILITY TO INFORM THE DOCTOR AND OFFICE STAFF OF ANY CHANGES IN MY MEDICAL STATUS.

PRINT NAME OF PATIENT, PARENT OR GUARDIAN

IF OTHER THAN PATIENT, RELATIONSHIP TO PATIENT

SIGNATURE

DATE

TOTAL FOOT AND ANKLE OF TAMPA BAY

TEL: 813-788-3600 / 813.633.5900 FAX: 813-788-7010

GUARANTEE OF PAYMENT

For and in consideration of the services provided to the patient, I agree to the following:

I promise to pay Total Foot and Ankle of Tampa Bay for all charges of services rendered to or on behalf of the patient.

It is the policy of this office to file all Medicare and secondary claims. In addition, Total Foot and Ankle of Tampa Bay will file private insurance as a courtesy to our patients. I understand that it is my responsibility to pay remaining amounts that insurance does not pay.

I understand that all co-pays and deductibles, and over-the-counter product fees will be collected at time of service.

In the event that a check for payment on my account is returned, for any reason, I will be responsible for the payment plus the maximum service charge allowed according to Florida State Statute 832.08(5) and 68.065(2)

If Total Foot and Ankle of Tampa Bay determines my account must be placed with a credit reporting agency or an attorney for collections, I will be responsible for the cost of collection including attorney fees.

Total Foot and Ankle of Tampa Bay shall make all reasonable efforts to assure that the insured is covered by the plan, but I understand that ultimately it is my responsibility to establish and understand my insurance benefits.

Patient / Guarantor Signature

Date

TOTAL FOOT AND ANKLE OF TAMPA BAY

TEL: 813-788-3600 / 813.633.5900 FAX: 813-788-7010

RELEASE OF INFORMATION

I authorize Total Foot and Ankle of Tampa Bay to release any medical or other information about me and the course of my treatment to any legal counsel, physician or insurance company requesting this information. I hereby release Total Foot and Ankle of Tampa Bay from any liability that can arise as a result of the use of the information contained in the records release.

Additionally, Total Foot and Ankle of Tampa Bay may release my health information to:

Name Relationship

Name Relationship

Name Relationship

Patient / Guarantor Signature Date

CHARGE FOR FORMS

I understand that there is a charge for all forms that I may need to be filled out or copied by Total Foot and Ankle of Tampa Bay:

Copied and faxed forms or forms given to patient: **\$1.00/page for the first 25 pages; then .25/page for any additional pages**

There is a \$25.00 fee for all forms that need to be filled out by the staff or by the doctors.

Patient / Guarantor Date

Total Foot and Ankle of Tampa Bay

This notice describes how your health information may be used and disclosed, and how you can access this information. Please review it carefully.

At *Total Foot and Ankle of Tampa Bay*, we are required to keep your health information secure and confidential, by law. Also by law, we need to give you this notice and to follow the terms of this notice.

The law permits us to use or disclose your health information to those involved in your treatment. For example, a review of your file by a specialist doctor whom we may involve in your care.

We may use or disclose your health information for payment of your services. For example, we may send a report of your treatment or progress to your insurance company.

We may use or disclose your health information for our normal healthcare operations. For example, one of our staff will enter your treatment information into our computer system.

We may share your medical information with our business associates, such as a billing service. We have a written contract with each business associate that requires them to protect your privacy.

We may use your information to contact you. For example, we may send newsletters or other information to you. We may also call and remind you about your appointments. If you are not home, we may leave this information on your answering machine or with the person who answers the telephone.

In an emergency, we may disclose your health information to a family member or another person responsible for your care.

We will need to release some or all of your health information, when required by law.

If this practice is sold, your information will become the property of the new owner.

Except as described above, this practice will not use or disclose your health information without your prior written authorization.

You may request in writing that we not use or disclose some or all of your health information as described above. We will let you know if we can fulfill your request.

You have the right to know of any uses or disclosures we make with your health information beyond the above normal uses.

You have the right to receive communication about your health information in the manner you prefer. We will also use whatever communication method, number or system you prefer to contact you.

You have the right to transfer a copy of your health information to another practice. Notify us in writing of where you would like us to send a copy of your health information for you.

You have the right to see and receive a copy of your health information, with a few exceptions. Give us a written request regarding the information you want to see. If you want a copy of your records, we may charge you a reasonable fee for the copies. If you would like a digital copy of your records, let us know which type of file you would like and we will try to meet your needs.

You have the right to request an amendment or change to your health information, in writing. If you wish to include a statement in your file, please give it to us in writing. We may or may not make the changes you request, but will include your statement in your file. If we agree to an amendment or change, we will not remove nor alter earlier documents, but will add new information.

You have the right to receive a report of who we disclose your information to.

If our privacy and security measures or systems are breached in any way, we will notify you.

You have the right to receive a copy of this notice.

If we change any of the details of this notice, we will notify you of the changes in writing.

You may file a complaint with the Department of Health and Human Services in writing (200 Independence Avenue, S.W., Room 509F, Washington, DC 20201), online (<http://www.hhs.gov>) or by email (OCRComplaint@hhs.gov). You will not be retaliated against for filing a complaint.

Please contact our Privacy Officer, Claudia Valins, at (813) 788-3600 for more information, to make a request, to file a complaint with us or for assistance regarding your health information privacy.

Acknowledgment

I have received a copy of the *Total Foot and Ankle of Tampa Bay* Notice of Privacy Practices.

Signed _____ Print Name _____ Date _____

If signing as a parent or guardian, please note the name of the patient _____