TOTAL FOOT AND ANKLE OF TAMPA BAY

PATIENT INFORMATION FORM

(PLEASE PRINT)

DATE: ____/_____/_____

PATIENT NAME: _____ _____ ____ SEX: □ M □ F

LAST FIRST MI

DATE OF BIRTH: ____/____/____ AGE: _____ SS# _____

HEIGHT: _____ WEIGHT: _____ SHOE SIZE: _____

HOME ADDRESS: _____

CITY/STATE: _____ ZIP: _____

HOME PHONE #: (_____) _____-_____ CELL PHONE #: (_____) _____-_____

WORK PHONE #: (_____) _____-_____ E-MAIL: _____

PRIMARY LANGUAGE: _____

ETHNICITY: □ HISPANIC OR LATINO □ NOT HISPANIC OR LATINO □ DECLINED TO SPECIFY

RACE: □ ASIAN □ AMERICAN INDIAN OR ALASKA NATIVE □ BLACK OR AFRICAN AMERICAN

□ WHITE □NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER □ DECLINED TO SPECIFY

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: _____ ADDRESS: _____

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

PHARMACY: _____ LOCATION: _____

PHONE #: (_____) _____-_____

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

ADDRESS: _____ CITY/STATE: _____ ZIP: _____

PHONE #: (_____) _____-_____

EMPLOYER _____ OCCUPATION _____

HOW DID YOU HEAR ABOUT US? _____

DO YOU LIVE IN FLORIDA YEAR ROUND? □ YES □ NO

IF NO, PLEASE GIVE OUT-OF-STATE ADDRESS: _____

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

FAMILY HISTORY

FAMILY HISTORY IS THERE ANY FAMILY HISTORY (BLOOD RELATIVE) OF: (PLEASE INDICATE FAMILY MEMBER)

☐ CANCER _____
☐ CORONARY ARTERY DISEASE _____
☐ DIABETES _____
☐ HEART DISEASE _____
☐ HIGH BLOOD PRESSURE _____
☐ RHEUMATOID ARTHRITIS _____
☐ STROKE _____
☐ THYROID DISEASE _____
☐ OTHER (PLEASE SPECIFY) _____

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

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

EXERCISE: ☐ NEVER ☐ARE ☐ 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 _____