FootCare Associates

DATE: ____/____/____

PATIENT NAME: _____ DATE OF BIRTH: ____/____/____ AGE: ___ SEX: M F

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

SOCIAL SECURITY NUMBER:_____

MAY WE LEAVE A MESSAGE?

HOME PHONE #: (___) ____-_____ [ ] YES [ ] NO

CELL PHONE #: (___) ____-_____ [ ] YES [ ] NO

E-MAIL: _____ [ ] YES [ ] NO

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

PRIMARY CARE DOCTOR NAME:_____

PHONE/ADDRESS:_____

WHO REFERRED YOU TO US? _____

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 #: (___) ____-_____

INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY NAME: _____

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

INSURED NAME: _____ DATE OF BIRTH _____ EMPLOYER _____

CONTRACT # _____ GROUP # _____ CARD HOLDER SS#_____

SECONDARY INSURANCE COMPANY NAME: _____

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

INSURED NAME: _____ DATE OF BIRTH _____ EMPLOYER _____

CONTRACT # _____ GROUP # _____ CARD HOLDER SS#_____

OVER

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? [ ] 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

YOUR MEDICAL HISTORY

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

NAME DOSE HOW OFTEN DO YOU TAKE?

ALLERGIES: [ ] NONE KNOWN [ ] MEDICATIONS _____

[ ] ANESTHESIA _____ [ ] FOODS _____

[ ] TAPE [ ] LATEX [ ] SHELLFISH [ ] IODINE [ ] OTHER_____

PATIENT NAME: _____

DATE OF BIRTH: ____/____/____

HAVE YOU EVER HAD ANY OF THE FOLLOWING? (PLEASE CHECK)

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

PLEASE LIST ALL PRIOR SURGERIES:

TYPE OF SURGERY	DATE	TYPE OF SURGERY	DATE
_____		_____	
_____		_____	
_____		_____	

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 _____

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? _____ TYPE _____

CURRENT USE TYPE _____ [ ] RARE [ ] OCCASIONAL [ ] MODERATE [ ] DAILY

EXERCISE: [ ] NEVER [ ] RARE [ ] OCCASIONAL [ ] WEEKLY [ ] SEVERAL TIMES A WEEK [ ] DAILY

TYPES OF EXERCISE: _____

OVER

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	SIGNATURE OF DOCTOR
_____	_____
IF OTHER THAN PATIENT, RELATIONSHIP TO PATIENT	DATE
_____	_____
SIGNATURE	DATE

FootCare
FootCare Associates, P.C.

Medical & Surgical Foot Specialists

Barry R. Mullen, DPM
Fawaz Nesheiwat, DPM
Kyle Alessi, DPM

SUMMARY OF NOTICE OF PRIVACY PRACTICES

(Summary is designed to assist you in understanding our Notice of Privacy Practices)

Health Information Use and Disclosure

FCA will use an disclose your health information for the following purposes; to treat you; to assist other health care providers in treating you; to allow insurance companies to process insurances claims for services rendered to you; to obtain payment for services rendered to you and for certain limited operational activities, such as quality assessment, licensing, accreditation and training of students. Except as stated in more detail in the Notice of Privacy Practices, we will not use or disclose your health information without your written consent.

Health Information Use and Disclosure Not Requiring Your Authorization

We may disclose your health information without written authorization under these circumstances:

- To family members or close friends who are involved in your health care
- For certain limited research purposes
- For public health and safety purposes
- To Government agencies for audits, investigations and other oversight activities
- To Government authorities to prevent child abuse or domestic violence
- To the FDA to report product defects or incidents
- To law enforcement authorities to protect public safety or assist apprehending criminals
- When requested by court orders, search warrants, subpoenas as required by law

Patient Rights

As our patient, you have the following rights

- To have access to and/or a copy of your health information
- To receive an accounting of certain health information disclosures we have made
- To request restrictions pertaining to how your health information is used and disclosed
- To request that we communicate with you in confidence
- To request that we amend your health information
- To receive notice of our privacy practices

Should you have any questions, concerns or complaints regarding our privacy practices, please refer to the actual Notice of Privacy Practices for the person(s) whom you may contact.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Notice of Privacy Practices and have read (or had the opportunity to read if I so chose) and understood the Notice.

Patient name/Authorized Representative (print) _____

Signature_____ Date_____

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