Oklahoma Foot & Ankle Treatment Center

NEW PATIENT INFORMATION

DATE: ____/____/____

NAME: _____ _____ ____ **SSN:**_____ **DOB:** ____/____/____ **SEX:** M F
LAST FIRST MI

HOME ADDRESS: _____ ZIP: _____ **EMAIL:**_____

PHONE#: CELL: _____ HOME: _____ WORK: _____

RACE:_____ **HEIGHT:**_____ **WEIGHT:**_____ **SHOE SIZE:**_____

EMERGENCY CONTACT: _____ RELATIONSHIP: _____ PHONE:_____

CAN WE SHARE YOUR MEDICAL INFORMATION WITH THIS PERSON? NO YES

PRIMARY CARE DOCTOR: _____ FAX. #:_____ **DATE LAST SEEN:**_____

PHARMACY: _____ LOCATION: _____ PHONE:_____

HOW DID YOU FIND OUT ABOUT OUR PRACTICE? ___PHYSICIAN ___INTERNET ___FRIEND ___OTHER:_____

WHOM CAN WE THANK FOR YOUR REFERRAL? _____

MEDICAL HISTORY (PLEASE FILL OUT COMPLETELY)

MEDICAL CONDITIONS:_____

_____

_____

CURRENT MEDICATIONS: (INCLUDE PRESCRIPTIONS, OVER-THE-COUNTER, & HERBAL SUPPLEMENTS)_____

_____

_____

ALLERGIES: ☐ NONE ☐ MEDICATIONS _____

☐ ANESTHESIA ☐ FOODS _____ ☐ TAPE ☐ LATEX ☐ IODINE ☐ OTHER _____

SURGERIES & ANY COMPLICATIONS: _____

_____

_____

RECENT HOSPITALIZATIONS: (WHY WERE YOU HOSPITALIZED AND WHEN) _____

_____

FAMILY HISTORY: WHAT CONDITIONS RUN IN YOUR FAMILY: (SIBLINGS, PARENTS, GRANDPARENTS) _____

_____

EXAMPLES: __DIABETES, __HEART DISEASE, _HIGH BLOOD PRESSURE, __STROKE, __THYROID DISEASE, __ RHEUMATOID ARTHRITIS, __CANCER

SOCIAL HISTORY

MARITAL STATUS: ☐ SINGLE ☐ MARRIED ☐ SEPARATED ☐ DIVORCED ☐ WIDOWED

ALCOHOL USE: ☐ NEVER ☐ QUIT – HOW LONG AGO____ ☐ CURRENT USE -HOW OFTEN: __RARE __OCCASIONAL __DAILY

TOBACCO USE: ☐ NEVER ☐ QUIT – HOW LONG AGO? _____ ☐ CURRENT USE _____ PACKS/DAY

RECREATIONAL DRUGS USE: ☐ NEVER ☐ QUIT – WHEN? _____ ☐ CURRENT USE– TYPE:_____

EMPLOYER: _____ OCCUPATION: _____

REVIEW OF SYSTEMS *(CIRCLE ALL THAT APPLY)*

GASTRO-INTESTINAL: NAUSEA /VOMITING /DIARRHEA / TROUBLE SWALLOWING /GERD / STOMACH ULCERS / LIVER DISEASE / HEPATITIS
GENITO-URINARY: KIDNEY DISEASE / DIALYSIS / FREQUENT URINATION / PAINFUL URINATION
NERVOUS SYSTEM: NUMBNESS / BURNING / TINGLING / POOR BALANCE / WEAKNESS / BLURRY VISION / FAINTING / CONFUSION
CARDIOVASCULAR: CHEST PAIN / FEET OR LEG SWELL / CALF PAIN / ARRHYTHMIA
RESPIRATORY: SHORTNESS OF BREATH / ASTHMA / COPD / WHEEZING / EMPHYSEMA / COUGH / PNEUMONIA
DERMATOLOGIC: RASH / OPEN WOUNDS / ITCHING / PSORIASIS / ECZEMA / DEFORMED NAILS / HIVES / SKIN CANCER
MUSCULOSKELETAL: OSTEO ARTHRITIS / RA / BACK PROBLEM / STIFFNESS / SCIATICA / MUSCLE PAIN / INSTABILITY / SPRAIN
HEMATOLOGIC: NOSE BLEEDS / BRUISE EASILY / ANEMIA / HIV / SICKLE CELL DISEASE

DESCRIBE THE REASON FOR TODAYS VISIT? _____

_____

_____

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, AND THAT IT IS MY RESPONSIBILITY TO INFORM THE DOCTOR AND OFFICE STAFF OF ANY CHANGES IN MY MEDICAL STATUS.

_____ _____ _____
SIGNATURE OF PATIENT OR GUARDIAN **PRINT NAME** **DATE**

IF OTHER THAN PATIENT, RELATIONSHIP TO PATIENT: _____

Oklahoma Foot & Ankle Treatment Center Policies and Procedures Agreement

HIPAA PRIVACY POLICY

I have received or been offered a copy of Oklahoma Foot & Ankle Treatment Center's Notice of Privacy Practices. I understand that my information will be used for the purpose of treatment, payment, and healthcare operations as described within.

Patient/Guardian Signature:_____ Date: _____

MEDICAL TREATMENT POLICIES

I hereby authorize the doctor to perform any and all forms of treatment, medication, and therapy that may be indicated in connection with the care of the patient with my consent. I understand that prior to treatment, the doctor or staff will give full explanation of the procedure(s) involved. I authorize the doctor to retrieve a list of my current medications in order to check for any possible interactions with my treatment.

Patient/Guardian Signature:_____ Date: _____

FINANCIAL POLICIES

I have read the attached document titled: Oklahoma Foot & Ankle Treatment Center Financial Policy I have read, understand, and agree to the Financial Policy of Oklahoma Foot & Ankle Treatment Center.

Patient Name(print):_____ Date:_____

Patient/Guardian Signature:_____ Date: _____

Being sensitive to the fact that different people have different needs in fulfilling their financial obligations, we are providing the following payment options to collect balances that become the patient's responsibility.

(Please pick one option or the other)

Option 1

_____ I choose as the guarantor and/or patient to have any balance that becomes my responsibility charged on the credit card number listed below as it becomes due. I understand that if the credit card number supplied is rejected or declined it is my responsibility to supply Oklahoma Foot & Ankle Treatment Center with a new credit card number promptly. **OR:**

Option 2

_____ I choose as the guarantor &/or patient to pay any balance that becomes my responsibility upon receipt of a statement. If any balance is not paid within 90 days the balance becomes my responsibility, the account may be turned over to our collection agency.

I understand that if I do not abide by the payment arrangement listed above, after 90 days, Oklahoma Foot & Ankle Treatment Center may turn my account over to a collection agency and I will be responsible for all collection and legal fees that the Practice incurs as a result.

Authorization signature: _____ Date: _____

Credit card: Type of card: MasterCard VISA Discover Other:_____

Name on card: _____

Card Number:_____ Exp._____ CCV:_____

Billing Address:_____ Zip Code:_____