PATIENT INFORMATION

Name: _____ Date: ___/___/___

Address: _____ City: _____ State: ____ Zip: _____

Home Phone: _____ Cell Phone: _____

SSN: _____ E-Mail: _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Partnered ☐ Minor

Ethnicity: ☐ American Indian ☐ Asian ☐ Black ☐ Hispanic ☐ Native Hawaiian ☐ White

Date of Birth: ___/___/___ Age: _____ Gender: ☐ Female ☐ Male Shoe Size: _____

Employer/School: _____ Occupation: _____

Employer/School Address: _____ Employer/School Phone:_____

Emergency Contact Name: _____ Emergency Contact Phone: _____

Whom may we thank for referring you? _____

INSURANCE INFORMATION

Primary Insurance Company: _____

Who is responsible for this account? _____ Relationship to Patient: _____

Insured DOB: ___/___/___ Insured SSN: _____ Employer: _____

Account Number: _____ Group Number: _____

Secondary Insurance Company: _____

Who is responsible for this account? _____ Relationship to Patient: _____

Insured DOB: ___/___/___ Insured SSN: _____ Employer: _____

Account Number: _____ Group Number: _____

Insurance Assignment and Release

I certify that I have insurance with the above company and assign directly to Dr. Morris /Maumee Bay Foot & Ankle Specialists all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. Dr. Morris and Maumee Bay Foot & Ankle Specialists may use my health care information and may disclose such information to the above-named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. In addition, I agree that my information can be used for collection purposes should I refuse to pay for services received in accordance to clinic financial policies.

Medicare/Medigap

I request that payment of authorized Medicare benefits and, if applicable, Medigap benefits, be made on my behalf to Dr. Morris/Maumee Bay Foot & Ankle Specialists for any services provided to me. To the extent permitted by law, I authorize any holder of medical or other information about me to release to the Centers for Medicare and Medicaid Services, my Medigap insurer, and their agents any information needed to determine these benefits or benefits for related services.

Missed Appointment Policy

I understand that a $25 fee is charge for missed appointments or appointments not rescheduled within 24 hours. This fee must be paid before an appointment is rescheduled.

_____ _____

Signature of Patient or Guardian Date

CHIEF COMPLAINT

1) What is the main problem with your feet or ankles? _____
_____

2) When did you first notice the condition? _____

3) Is this an injury? ____Yes ____No If Yes, when did it occur? ____/____/____
If Yes, did it happen at work? ____Yes ____No Are you claiming Workman's Comp? ____Yes ____No

4) Check all of the following that apply:

Type of Pain ___Burning ___Tingling ___Sharp ___Dull Ache ___Throbbing
___Shooting ___Stabbing ___Numbness

When Painful ___Upon Standing ___During Walking ___After Walking
___During Sports ___Worse with Activity ___Better as Activity Continues
___Worse when standing ___With Shoes ___Without Shoes
___A.M ___P.M ___Lying in Bed ___Always

5) How painful is your condition? If **0** = "no pain" and **10** = "the worst pain you have ever experienced", please circle your pain level: **0 1 2 3 4 5 6 7 8 9 10**

6) How has this affected your daily routine and what activities does this keep you from performing? _____
_____

7) Have you had foot care before? ____Yes ____No By whom and when: _____

_____

MEDICATIONS

Pharmacy: _____ Location: _____

Medication	Dosage	How Often Taken?	What is it Taken for?

PRIMARY CARE PHYSICIAN

Primary Care Physician(s): _____ City: _____

Phone: _____ Last Visit Date: ___/___

ALLERGY INFORMATION

☐ NONE ☐ OTHER _____

☐ Penicillin ☐ Sulfa ☐ Iodine ☐ Aspirin ☐ Anesthetics ☐ Latex

☐ Codeine ☐ Demerol ☐ Darvocet ☐ Cortisone ☐ Environmental ☐ Food

Type of Reactions:_____

MEDICAL HISTORY

* Please check any of the following conditions that you have or have had in the past.

☐ Diabetes ☐ Fibromyalgia ☐ Tumors ☐ Epilepsy ☐ Nerve Conditions ☐ Heart Problems

☐ Arthritis ☐ Gout ☐ Asthma/COPD ☐ Glaucoma ☐ Stomach Ulcers ☐ Skin Disorders

☐ Tuberculosis ☐ Anemia ☐ Bursitis ☐ Aids (HIV) ☐ Lung Disease ☐ Kidney Problems

☐ Sickle Cell ☐ Stroke ☐ Hepatitis ☐ Osteoporosis ☐ Bleeding Problems ☐ Colitis / Crohn's

☐ Mental Disorders ☐ Poor Circulation ☐ High Blood Pressure ☐ Joint Implants ☐ Thyroid Disease

☐ Rheumatic Fever ☐ Heart Burn / Reflux ☐ Sexually Transmitted Diseases ☐ High Cholesterol

☐ Cancer; type _____ Other: _____

☐ Diabetes; What is the name of the doctor treating you for diabetes? _____

When was your last visit? ____/____/____ Average blood sugar reading? _____

Last A1C: _____ Approximate last A1C date: ____/____/____

Are you pregnant? ____Yes ____No How many months? _____

SURGICAL HISTORY

Procedure	Date	Complications

7) Have you ever been hospitalized other than for surgery? ____Yes ____No Explain_____

_____

8) Have you ever had an injury to the lower extremity? ____Yes ____No Explain _____

_____

FAMILY HISTORY

* Please check all that apply

	FATHER	MOTHER	BROTHER	SISTER
Diabetes				
Heart Disease				
High Blood Pressure				
Arthritis				
Gout				
Thyroid				
Cancer (what type)				
Other				

SOCIAL HISTORY

Date of last physical Exam: ____/____/____

Physical Activities: _____

Level of activity: ____Occasional ____Weekly ____Competitive ____Professional

Do you smoke tobacco? ____Yes ____No

If Yes: # packs per day? ____ # of years smoking? ____

If No: Did you ever smoke? ____Yes ____No

If Yes: How long ago did you stop smoking? _____

Do you drink alcohol? ____Yes ____No

If Yes: How much? ____< 1 per week ____1-2 per week ____1-2 per day ____more than 3 per day

Recreational drug use? ____Yes ____No

Acknowledgement of Receipt of Notice of Privacy Practices

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

_____ _____

Patient Name (Please Print) Date

_____

Parent or Authorized Representative (if applicable)

_____

Signature

Electronic Access to Your Health Information

Part of your rights as a patient is to receive all of your health documents on a timely basis as well as electronically. Maumee Bay Foot & Ankle asks for your email address to send you your visit notes, educational resources, as well as any other important health notices in a secure manner. Please provide an updated email below and all of your health records will be sent to you electronically through a national healthcare site known as Health Vault using the email you provide.

Patient name: _____

Patient email: _____

I decline electronic communication at this time _____
(Signature)

Maumee Bay Foot & Ankle Specialists, LLC
Summary of Notice of Privacy Practices

This summary is provided to assist you in understanding our Notice of Privacy Practices, which is available upon request

The available Notice of Privacy Practices contains a detailed description of how out office will protect your health information, your rights as a patient and our common practices in dealing with patient health information. Please refer to that Notice for further information.

Uses and Disclosures of Health Information. We will use and disclose your health information in order to treat you or to assist other healthcare providers in treating you. We will also use and disclose your health information in order to obtain payment for our services or to allow insurance companies to process insurance claims for services rendered to you by us or other healthcare providers. Finally, we may disclose your health information for certain limited operational activities such as quality assessment, accreditation, and training of students.

Uses and Disclosures Based on Your Authorization. Except as stated in more detail in the available Notice of Privacy Practices, we will not use or disclose your health information without your written authorization.

Uses and Disclosures Not Requiring Your Authorization. In the following circumstances, we disclose your health information without your written authorization:

- To family members or close friends who are involved in your healthcare
- For certain limited research purposes
- For purposes of public health and safety
- To Governmental agencies for purposes of their 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 to assist in apprehending criminal offenders
- When required by court orders, search warrants, subpoenas and as otherwise required by the law.

Patient Rights. As our patient, you have the following rights:

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

If you have question, concern, or complaint regarding our privacy practices, please refer to the available Notice of Privacy Practices for the person or persons whom you may contact.