The Foot & Ankle Center of St Charles County

PATIENT INFORMATION

Please complete the form and sign. All information is confidential.

LEGAL FIRST NAME: ____________________________ MI: _______ LAST NAME: ____________________________________

NAME YOU GO BY: ________________________ BIRTH DATE: _____/ ______/ _______ GENDER: ___________________

SOCIAL SECURITY NUMBER: _________- _______- _____________

STREET ADDRESS: ____

CITY: ____ STATE: _____________ ZIP: _______________________

CELL PHONE (_______) _______- _________ HOME: (______) _______- __________ WORK: (____) ______-__________

EMAIL ADDRESS: ____

EMPLOYMENT STATUS: ________________ EMPLOYER/ SCHOOL: ____

DAILY ACTIVITIES: ____

EMERGENCY CONTACT NAME: ____

PHONE #: (_______) ________- _________ RELATIONSHIP: ____

PRIMARY CARE PHYSICIAN: ____ PHONE: (______) _______-_________

HOW DID YOU HEAR ABOUT OUR FACILITY: ☐FAMILY ☐FRIEND ☐INTERNET ☐DOCTOR ☐OTHER:_______________

RESPONSIBLE PARTY (IF MINOR)

PERSON RESPONSIBLE FOR ACCOUNT: ____________________________________ RELATIONSHIP: ___________________

PHONE #: (_______) ________- _________ BIRTH DATE: ______/ _______/__________ SSN #: ______- _______- _________

EMPLOYER: ____

REASON FOR TODAY'S VISIT

WHAT BRINGS YOU IN TODAY:____

DATE OF ONSET: ____________________________________ LOCATION: ____

IS THIS WORK RELATED: ☐YES ☐NO IF YES, WHAT HAPPENED: ____

INSURANCE INFORMATION

PRIMARY INSURANCE:

INSURANCE COMPANY: ______________________________ MEMBER ID #: ____

GROUP NAME: _____________________________________ GROUP #: ____

POLICY HOLDER NAME: ______________________________ RELATIONSHIP TO PATIENT: ____________________________

BIRTH DATE: _______/ _______/ _________ SSN #: _______- _______- _________

SECONARY INSURANCE:

INSURANCE COMPANY: ______________________________ MEMBER ID: ____________________________________

GROUP NAME: ______________________________________ GROUP #: ______________________________________

POLICY HOLDER NAME: ____________________________ RELATIONSHIP: _______________________________

POLICY HOLDER'S BIRTH DATE: _________________________ SSN: _____________-______________-_____________

I, HEREBY AUTHORIZE, FOOT & ANKLE CENTER OF ST. CHARLES COUNTY, TO RELEASE ANY MEDICAL RECORDS OR INFORMATION NECESSARY TO PROCESS THIS CLAIM AND ANY FUTURE CLAIMS THAT I MAY HAVE. I ALSO AUTHORIZE PAYMENT OF MEDICAL BENEFITS DRIECTLY TO THE PHYSICIAN AND/OR PROVIDER AS LONG AS I AM A PATIENT. IF IT IS NECESSARY TO INVOLVE A THIRD-PARTY COLLECTOR OR AN ATTORNEY FOR PAYMENT OF SERVICES, I WILL BE RESPONSIBLE FOR ALL COST OF COLLECTION IN THE EVENT OF DEFAULT. I UNDERSTAND THAT I, THE PATIENT, HAVE A CONTRACT WITH MY INSURANCE COMPANY, NOT WITH DR. KRANZUSCH (FOOT & ANKLE CENTER OF ST. CHARLES COUNTY), AND IF FOR SOME UNFORESEEN REASON THERE IS A DISPUTE WITH MY CLAIM, I, THE PATIENT, WILL BE RESPONSIBLE FOR THE COST OF SERVICES GIVEN TO ME BY FOOT & ANKLE CENTER OF ST. CHARLES COUNTY.

RESPONSIBLE PARTY SIGNATURE: _____________________________________ DATE: ______/ _______/ ________

REVIEW OF SYSTEMS

(PLEASE CIRCLE ALL THAT APPLY)

CONSITUTIONAL: CHANGE IN APPETITE CHILLS FATIGUE FEVER NIGHT SWEATS WEAKNESS

EYES: CATARACTS VISION LOSS

ENT / EARS: HEARING LOSS DIFFICULTY BREATHING HEAD / NECK BLEEDING SINUS PROBLEMS

RESPIRATORY: ASTHMA LUNG PROBLEMS SHORTNESS OF BREATH TUBERCULOSIS EXPOSURE

CARDIOVASCULAR: BLOOD CLOTS CHEST PAIN CRAMPS FEET SWELL HANDS SWELL HEART ATTACK HEART MURMUR LEG PAIN POOR CIRCULATION VARICOSE VEINS

MUSCULOSKELETAL: ARTHRITIS BACK PAIN BONE PAIN FIBROMYALGIA FRACTURES JOINT PAIN MUSCLE PAIN SPRAINS STIFFNESS

PSYCHIATRIC: ANXIETY DEPRESSION PSYCHIATRIC DISORDERS

SKIN: BRUISING DEFORMED NAILS DISCOLORATION OF NAILS ITCHING RASHES SCARRING TENDENCIES SKIN ULCERATION

NEUROLOGIC: DIZZINESS HEADACHE NUMBNESS/ TINGLING PARALYSIS SEIZURES

ENDOCRINE: DIABETIC TYPE I DIABETIC TYPE II THYROID PROBLEMS

HEMATOLOGIC/ LYMPHATIC: ANEMIA BLEEDS EASILY ASPIRIN USE

URINARY: BLADDER TROUBLE FREQUENT URINATION KIDNEY DISEASE KIDNEY STONES PROSTATE TROUBLE

☐NONE OF THIS PERTAINS TO ME (PLEASE CHECK BOX IF NONE APPLY TO YOU)

ALLERGIES

PLEASE LIST ALL ALLERGIES: ____

TYPE OF ALLERGIC REACTION: ____

☐ **NO KNOW ALLERGIES (PLEASE CHECK BOX IF NO KNOW ALLERGIES)**

PHARMACY

PHARMACY NAME: ____

STREET ADDRESS: ______________________________ CITY: ____________________

STATE: __________ ZIP: ____________ PHONE #: (______) ________-____________

DO WE HAVE CONSENT TO VIEW YOUR PRESCRIPTION HISTORY? ☐ **YES** ☐ **NO**

IF NOT, PLEASE LIST ALL MEDICATIONS YOU USE:____________________________________

____

____

FAMILY HISTORY

(PLEASE CIRCLE ANY CONDITIONS THAT APPLY TO FIRST DEGREE RELATIVE)

ANEMIA ANXIETY ARTHRITIS ASTHMA BACK PROBLEM CORONARY ARTERY DISEASE(CAD)

CONGESTIVE HEART FAILURE (CHF) CHRONIC OBSTRUCTIVE PULMONARY DISEASE (COPD) CANCER

HIGH CHOLESTEROL DEMENTIA DEPRESSION DIABETES GOUT

HIGH BLOOD PRESSURE (HTN) HEART ATTACK (MI) STROKE THYROID DISEASE GI ULCER

MEDICAL HISTORY

(PLEASE CIRCLE ANY CONDITION THAT APPLIES TO YOU)

AIDS ABSCESS ALZHEIMER'S DISEASE ANGINA ANXIETY BREAST CANCER COPD

CATARACTS CEREBAL PALSY CHARCOT'S JOINT CIRRHOSIS COAGULATION DISORDER

DEEP VEIN THROMBOSIS DEPRESSION DIABETES DIZZINESS ECZEMA EMPHYSEMA

FIBROMYALGIA GALLBLADDER CANCER GALLBLADDER ISSUES GASTRITIS GOUT

HIV HEADACHE HEART MURMUR HEPATITIS HYPERTENSION HYPERTHROIDISM

HYPOTHYROIDISM LEUKEMIA LIPOMA OSTEOMYELITIS OSTEOPOROSIS PARKINSON'S DISEASE

PROSTATE ISSUES PSORIASIS RENAL FAILURE SEIZURE SINUSITIS SPRAIN

STROKE THYROID CANCER

SOCIAL HISTORY

(PLEASE CIRCLE IF APPLICABLE)

TOBACCO USAGE: NEVER FORMER CURRENT **ESTIMATED YEARS OF USAGE**: __________

TYPE OF USAGE: CIGARETTES CIGARS PIPE CHEWING TOBACCO DIPPING TOBACCO

ALCOHOL USAGE: NEVER SOCIAL HEAVY

TYPE OF ALCOHOL USAGE: BEER WINE HARD LIQUOR

MARIJUANA USAGE: NEVER RECREATIONAL DAILY

OTHER: ____

SURGICAL HISTORY

PLEASE LIST ALL PREVIOUS SURGERIES & DATES OF SURGERIES: ______________________________

____

ANY COMPLICATIONS WITH ANESTHESIA: ☐ YES ☐ NO IF YES, PLEASE EXPLAIN: ______________

VITAL SIGNS

SHOE SIZE:__________ WEIGHT: __________ HEIGHT:__________

LAST A1C LEVEL (if applicable): __________

I CERTIFY THAT THE INFORMATION GIVEN IN THIS PATIENT REGISTRATION PACKET IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE. I GRANT PERMISSION TO THE FOOT & ANKLE CENTER OF ST CHARLES COUNTY TO ADMINISTER AND PERFORM SUCH PROCEDURES AS MAY BE DEEMED NECESSARY IN THE DIAGNOSIS AND/ OR TREATMENT OF MY CONDITION(S).

PATIENT NAME (PRINT): ______________________________ **DATE:** ____/________/__________

RESPONSIBLE PARTY SIGNATURE: ____

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

PROTECTED HEALTH INFORMATION (PHI) REFERS TO ANY INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION THAT IS CREATED, USED, OR DISCLOSED IN CONNECTION WITH THE PROVISION OF HEALTHCARE SERVICES, PAYMENT FOR HEALTHCARE, OR HEALTHCARE OPERATIONS.

EXAMPES OF PHI INCLUDE: NAME, ADDRESS, PHONE NUMBER, DATE OF BIRTH, MEDICAL HISTORY, TEST RESULTS, DIAGNOSES, TREATMENT INFORMATION, AND INSURANCE INFORMATION.

PHI IS PROTECTED UNDER THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA), WHICH ESTABLISHES NATIONAL STANDARDS TO SAFEGUARD THE PRIVACY AND SECURITY OF THIS INFORMATION. HEALTHCARE PROVIDERS, HEALTH PLANS, AND CLEARINGHOUSES ARE REQUIRED TO FOLLOW THESE STANDARDS TO ENSURE THAT PHI IS HANDLED APPROPRIATELY.

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 UNDERSTAND THE NOTICE.

PATIENT NAME (PLEASE PRINT): ____ **DATE:**_____/_______/__________

SIGNATURE OF RESPONSIBLE PARTY: ____

RELEASE OF MY PROTECTED HEALTH INFORMATION

THIS FORM IS OPTIONAL

(PLEASE PRINT BELOW INFORMATION)

I, ______________________________________ HERBY AUTHORIZE RELEASE OF MY PROTECTED HEALTH INFORMATION FOR VERBAL DISCUSSION ONLY OF MY CARE AND TREATMENT TO THE PERSON(S) SPECIFIED BELOW:

NAME: ____

PHONE #: (______) ________-___________ **RELATIONSHIP:** _____________________

NAME: ____

PHONE #: (_______) ________- ____________ **RELATIONSHIP:** ____________________

NAME: ____

PHONE #: (_______) ________-____________ **RELATIONSHIP:** _____________________

NOTE: THIS FORM GIVES THE ABOVE REFERENCED PERSON(S) PERMISSION TO MAKE HEALTH CARE DECISIONS FOR YOU, THE PATIENT, OR ENTITLES THEM TO PAPER COPIES OR ELECTRONIC ACCESS OF YOUR MEDICAL RECORD. WE WILL NOT RELEASE VIA THE TELEPHONE OR ANY OTHER MEANS OF COMMUNICATION INFORMATION TO ANY FRIENDS OR FAMILY MEMBERS NOT LISTED ABOVE UNLESS THE PATIENT HAS AN OPPORTUNITY TO OBJECT AND DOES NOT (DOCUMENTED), OR IS REASONABLE TO INFER THAT THE PATIENT DOES NOT OBJECT SUCH AS WHEN A PATIENT BRINGS A SPOUSE INTO THE EXAM ROOM WHEN TREATMENT IS BEING DISCUSSED.

EXCEPTION: IF THE RELEASE IS NEEDED IN EMERGENCY SITUATIONS.

EXCEPT TO THE EXTENT THAT ACTION HAS ALREADY BEEN TAKEN IN RELIANCE ON THIS PROTECTED HEALTH INFORMATION AUTHORIZED PERSON(S), AT ANY TIME I CAN REVOKE THIS PROTECTED HEALTH INFORMATION AUTHORIZED PERSON(S) BY SUBMITTING A NEW PROTECTED HEALTH INFORMATION AUTHORIZED PERSON(S) FORM OR BY WRITTEN NOTICE TO THE FOOT AND ANKLE CENTER OF ST CHARLES COUNTY WHERE MT MEDICAL RECORDS ARE KEPT.

BY SIGNING AND DATING THIS PROTECTED HEALTH INFORMATION AUTHORIZED PERSON(S) FORM, I REVOKE ALL PREVIOUSLY SIGNED PROTECTED HEALTH INFORMATION AUTHORIZED PERSON(S) FORMS.

PRINT PATIENT NAME: ____

SIGNATURE OF RESPONSIBLE PARTY: ____

DATE: ______/ _______/ __________