The Foot and Ankle Clinic of West Monroe LLC

WELCOME TO OUR OFFICE!!

NEW PATIENT INFORMATION FORM

(PLEASE PRINT CLEARLY)

Patient Name: _____ Sex: M/F Date of Birth: _____/_____/_____ Age:

Last First MI

Home Address: _____ City/ State: _____ / _____ Zip:

SSN:_____-_____-

Home Phone #: (_____)_____-_____ Marital Status:

Cell Phone #: (_____)_____-_____ Race:

Work Phone #: (_____)_____-_____ Ethnicity:

E-mail: _____ Language Preferred:

Your preferred method of communication *(Please check one)*: □Home □Cell □Work □E-mail

May we call and leave a message?:□Yes □ No May we send text messages to your cell phone: : □Yes □No

Emergency Contact: _____ Relationship to Patient:

Home Phone: (_____)_____-_____ Cell Phone #: (_____)_____-

2 People We May Release Medical Records To:

1. Name: _____Relationship to Patient: _____ Contact Phone:(_____)_____-

2. Name: _____Relationship to Patient: _____ Contact Phone:(_____)_____-

Who is responsible for payment? □self □other: _____ relationship to patient:

address: _____ phone #: (_____)_____-

Does the patient have a legal guardian or health-care power of attorney? *(please check one one)*: □Yes □No

If yes, Name: _____ Relationship: _____ Phone

#: (_____)_____-

Primary Care Doctor: _____ Phone #: (_____)_____-

Date last seen:

Pharmacy: _____ Address: _____ Phone #: (_____)_____-

Are you currently under a pain management contract or receiving narcotics of any kind from another physician?*(please check one one)*: □Yes □No ***If Yes, Who?***

Are you currently under the care of a hospice?: □Yes □No

Are you here today for an injury that occurred while at work or is this accident related?: □Yes □No

To the best of my knowledge, I have answered the questions on this form and the following pages 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. I have read the hipaa notice of privacy practices. I understand that I may obtain my own copy of it by requesting it. I have read and understand your "improving your office visit" statement. I have read, understand and agree to comply with your "patient financial policy".

_____

Print name of patient, parent or guardian **relationship to patient**

Signature **Today's date**

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New patient registration form **Page 2**

Current Foot Or Ankle Problem:

what specific problem brings you to our office today?
where is the pain/problem located? *(Please mark on the pictures below):*

Bottom of Foot
Top of Foot
Top of Foot
Bottom of Foot

Outside of Foot
Inside of foot
Outside of Foot
Inside of foot

Pain at worst *(please circle one):* 0 1 2 3 4 5 6 7 8 9 10

Type of pain *(check all that apply):* □sharp □dull □burning □tingling □numbness □aching □other

Was this caused by an injury? □YES □NO If yes, please specify:

Have you been treated for this condition in the past? □YES □NO If yes, please specify:

_____

_____

Allergies: □ None Known □

Medications_____

_____

□ Foods _____ □ Sulfa □ Tape/Adhesives □ Latex □ Shellfish/Iodine

□ Other

_____

_____

Please list all medications you take or provide us with a medication list (Including over the counter):

Medication Dose Medication Dose

_____

_____

_____

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_____

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Have you ever had any of the following?:

Acid Reflux	Y	N		Fibromyalgia	Y	N		Open Sores	Y	N
Anemia	Y	N		Gout	Y	N		PAD/ PVD	Y	N
Arthritis	Y	N		Heart Attack	Y	N		Pneumonia	Y	N
Asthma	Y	N		Heart Disease/ Failure	Y	N		Plantar Fasciitis	Y	N

Abnormal Bleeding	Y	N		Hepatitis	Y	N		Polio	Y	N
Back Trouble	Y	N		HIV +/ AIDS	Y	N		Rheumatic Fever	Y	N
Bladder Infections	Y	N		High Blood Pressure	Y	N		Sickle Cell Disease	Y	N
Blood Clots/ DVT	Y	N		Kidney Disease	Y	N		Skin Disorder	Y	N
Blood Transfusion	Y	N		Liver Disease	Y	N		Sleep Apnea	Y	N
Bronchitis/ Emphysema	Y	N		Low Blood Pressure	Y	N		Stomach Ulcers	Y	N
Cancer	Y	N		Lupus	Y	N		Stroke	Y	N
CAD	Y	N		Lymphedema	Y	N		Thyroid Disease	Y	N
Diabetes	Y	N		Migraine Headaches	Y	N		Tuberculosis	Y	N
Edema	Y	N		Mitral Valve Prolapse	Y	N		Varicose Veins	Y	N
Epilepsy/ Seizures	Y	N		Neuropathy	Y	N		Warts	Y	N
Other:										

Social History

Use of Tobacco: ☐ Never ☐ Quit – how long ago? _____ ☐ Smoke packs/day for ____ years

Use of Alcohol: ☐ Never / No longer use ☐ History of alcohol abuse

☐ Current USE - Type _____ ☐ Rare ☐ Occasional ☐ Moderate ☐ Daily

Use of Recreational Drugs: *(Please notify doctor in room)*

Do others depend upon you for their care? ☐ Children–age(s) _____ ☐ Pet(s)–what kind?

☐ Elderly or disabled family member ☐ Other

_____

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

_____

_____

Relationship to patient:

_____

_____

Surgical History **Date** **Surgical History** **Date**

_____

_____

_____

_____

_____

_____

_____

_____

Prior Hospitalizations *(other than surgeries)*: Please include reason and date