Patient History

Name: ______________________________ Date: ______________

What is the main problem you are having? ______________________________

Date symptoms first occurred or injury happened: ______________________________

If injury, where did the accident occur? ______________________________

What symptoms are you having? (pain, swelling, etc.) ______________________________

Has another doctor treated you for this problem? ______________________________

What kind of treatment was done? ______________________________

Have you treated yourself for this problem? (Advil, Aspirin, etc.)______________________________

Have you ever injured this area before? ______________ If so, when? ______________

Family Physician ______________________________Date of last visit ______________

Hospital Preferred ______________________________ Pharmacy ______________

Past Medical / Family History

Do you and/or any family member have: (indicate with P for patient and F for family next to each that apply)

Anemia / Blood Disorder	Headaches	High Blood Pressure	Low Back Pain
Stomach / Reflux / Bowel Disorder	Liver Disease / Hepatitis	Arthritis / Gout	Foot/Leg Cramps
Psychiatric Disorder / Depression	Cancer (Type_________)	Lupus	Foot/Leg Numbness
Epilepsy / Neurological Disorder	Thyroid Disease	Foot / Ankle Ulcer	Foot/Ankle Surgery
Stroke / Polio	Diabetes	Toenail Problems	Foot Pain / Injury
Asthma / COPD	Heart Disease / Heart Attack	Bunions / Hammertoe	Ankle Pain / Injury
Kidney / Stones / Bladder Problems	High Cholesterol	Varicose Veins	Knee Pain / Injury

What types of surgery have you had in the past? Complications? ______________________________

Have you recently been in the hospital?______________________________

If so, which hospital and why? ______________________________

Have you had a Flu Shot in the past 12 months ____________ Have you ever had a Pneumonia Vaccine ____________

Do you consume tobacco? ______________ If so, how much per day? ____________ Number of Years? ________

Do you consume alcohol? ______________ If so, how much per week? ______________________________

Do you consume any illegal drugs? ____________ If so, what and how much per week? ______________________________

Do you have any allergies to medications? ________ If so, what? ______________________________

List Medications (prescription, over-the-counter, supplements/vitamins)? ______________________________

____

Is there anything else the doctor should be aware of? ______________________________

Signature ______________________________ Date ______________

PATIENT INFORMATION

How Did You Hear About Dr. Walter W. Hayes?

Television Radio Magazine Yellow pages Internet Friend Other____________

Patient Name	Birth Date / /	Age	Gender	Date
Street (Physical) Address	SS# (needed for billing) - -		Marital Status	

Mailing Address	City and State	Zip Code	Home Phone # ( ) -
Patient's Employment	Occupation (indicate if student)	How long employed	Cell Phone # ( ) -
Employer's Address	City and State	Zip Code	Work Phone # ( ) -

If you would like to be able to access your medical records over the internet via a secure web portal please provide your email address:

RESPONSIBLE PARTY / SPOUSE INFORMATION

Name	Address if different	SS# (needed for insurance billing) - -	Birth Date / /
Employer	Occupation	Work Phone # ( ) -	
Employer's Address	City and State	Zip Code	

INSURANCE INFORMATION - Please present cards to Front Desk

In Case of Emergency Contact: Name____

Address ________________________________ Home Phone_______________ Work Phone ____________

FINANCIAL AGREEMENT & AUTHORIZATION FOR TREATMENT

I authorize treatment of the person named and authorize information given to insurance companies. I agree to pay all charges shown by statements, promptly upon presentation thereof unless credit arrangements are agreed upon in writing by the office. I agree to forward any and all insurance checks that are for payment for charges to this company. Charges shown by statement are agreed to be correct and reasonable unless protested in writing within 30 days.

It is agreed that payments will not be delayed or withheld because of my insurance coverage to the pendency of claims thereon, and all proceeds of insurance are assigned to the physician providing treatment, but without the office assuming responsibility for the collect thereof. I also understand services could be deemed non-covered by my insurance plan due to policy exclusion or medical necessity and any amount owed is still my financial responsibility.

Responsible Party Signature ____

MEDICARE SIGNATURE ON FILE

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Dr. Hayes for any services furnished to me by that physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services.

Patient's Signature ____

OTHER INSURANCE SIGNATURE ON FILE

I request that payment of authorized Insurance benefits be made either to me or on my behalf to Dr. Hayes for any services furnished to me by that physician. I authorize any holder of medical information about me to be released in order to process any insurances claims on my behalf.

Patient's Signature ____

Patient Name: ______________________________

Date of Birth: ______________________________

Review of Current Symptoms	YES	NO
Swelling of legs		
Chest pain		
Palpitations		
Chills		
Fever		
Headache		
Extreme thirst		
Tired/sluggish		
Weight change (Recent)		
Difficulty hearing		
Sore throat		
Sinus problems		
Glasses/contacts		
Loss of vision		
Constipation		
Heartburn		
Vomiting		
Diarrhea		
Nausea		
Anemia		
Bleeding problems		
Blood clot in leg		
Bruise easily		
Non-healing wound		
Rash		
Foot/ankle pain		
Leg cramps		
Leg pain		
Back pain		
Difficulty walking		
Numbness		
Paralysis		
Paresthesia (burning, tingling, shooting)		
Seizures		
Weakness		
Psychiatric or emotional difficulties		
Depression		
Cough		
Shortness of breath		
Wheezing		

Date of Visit ________

PLEASE MARK THE SYMPTOMS WHICH APPLY TO YOU TODAY