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

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 ONLY THE SYMPTOMS THAT APPLY TO YOU TODAY

*indicates ongoing or historical symptoms