

## 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 Family Foot & Ankle Center. 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.

I request that payment of authorized Commercial Insurance and/or Medicare/Medicaid benefits be made on my behalf to Family Foot & Ankle Center for any services furnished to me by their physician. I authorize any holder of medical information about me to be released in order to process any insurance claims on my behalf. This may include agents from my Commercial Insurance Company and/or the Centers for Medicare & Medicaid Services including their subcontractor/affiliated companies all in order to process insurance claims properly.

Patient or Guardian Signature \_\_\_\_\_  
 (For Medicare/Medicaid/Commercial Insurance Signature On File)

Patient Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Review of Current Symptoms

YES NO

Date of Visit \_\_\_\_\_

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		

**PLEASE MARK THE  
SYMPTOMS WHICH  
APPLY TO YOU TODAY**