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 ABOVE 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? _____

Flu Shot in past 12 months? **YES / NO** Ever had a Pneumonia Vaccine? **YES / NO** COVID19 Vaccine? **YES / NO**

Do you consume tobacco? **YES / NO** If so, how much per day? _____ Number of Years? _____

Do you consume alcohol? **YES / NO** If so, how much per week? _____

Do you consume any illegal drugs? **YES / NO** If so, what and how much per week? _____

Do you have any allergies to medications? **YES / NO** If so, what? _____

Prescription Medications (include Name, Dosage, and How Often Taken)? _____

_____

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: _____

Review of Current Symptoms	YES	NO
Swelling of legs		
Chest pain		
Fever		
Weight Change (Recent)		
Glasses / Contacts		
Heartburn		
Bleeding Problems		
Non-healing Wound		
Foot / Ankle Pain		
Back Pain		
Difficulty Walking		
Paresthesia (burning, tingling, shooting)		
Weakness		
Shortness of Breath		

PLEASE MARK THE SYMPTOMS WHICH APPLY TO YOU TODAY

Signature _____ Date _____

ACKNOWLEDGMENT

OF

PRIVACY PRACTICES

I acknowledge that I was made aware of the Notice of Privacy Practices and that I have read (or had the opportunity to read if I so chose) and understand the Notice.
A copy will be provided upon request or you can download from our website.

_____ _____

Patient Name (please print) Date

_____

Parent or Authorized Representative (if applicable)

_____

Signature