

**Last Name**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **First Name** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Sex:** **M\_\_\_ F\_\_\_**

**Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_State\_\_\_\_\_\_\_ Zip\_\_\_\_\_\_\_\_**

**SS#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age\_\_\_\_\_ Marital Status: S\_\_\_ M\_\_\_ W\_\_\_ D\_\_\_ SEP\_\_\_**

**Date of Birth**\_\_\_\_\_\_\_\_\_\_\_\_ **Primary Phone**\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Other** **Phone**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Email\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Patients Employer\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Position\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Employers Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Work #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**If the patient is a student, name of school \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Spouse’s Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Spouse’s Employer\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Primary insurance\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ID #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group#\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Secondary insurance\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ID#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group #\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Primary Physician \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone Number\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Other Physician \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone Number\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**How did you hear about our office? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**EMERGENCY CONTACT**

**Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Relationship\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Address (if different from above) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Employer\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Employer Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Benefits to Physician/ Statement of Financial History**

I hereby authorize payments to the physician of all medical/ surgical benefits. I understand and agree that I am responsible for the balance of my bill not paid by my insurance company for any professional services rendered. I also understand that it is my responsibility to notify the office of any changes in my health status, primary care, and my insurance status.

**Release of Information**

I hereby authorize the release of my medical information to my insurance carrier, my primary care physician, and many consulting physicians as part of the normal process in the delivery of healthcare. This release of information may include record of communicable diseases such as syphilis, gonorrhea, hepatitis, HIV and AIDS

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Date Signature**

**PERSONAL MEDICAL INFORMATION**

**What is the reason for your visit?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Any past problems with your feet or ankles, including any surgical procedures? If yes, please describe**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Have you seen a podiatrist before? \_\_\_\_ If yes, who? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**What is your shoe size? \_\_\_\_\_\_\_\_ Your current weight? \_\_\_\_\_\_Your height? \_\_\_\_\_\_**

**GENERAL HEALTH INFORMATION**

**Do you have diabetes? YES\_\_\_NO\_\_\_ If yes, do you take insulin? YES\_\_\_\_ NO\_\_\_\_**

**How long have you had diabetes?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Have you had any operations? If yes, describe** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Are you under a physicians care? YES\_\_\_\_ NO\_\_\_\_\_**

**For what condition are you being treated?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Date you last saw your physician? \_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**May we contact your doctor about your health? YES\_\_\_\_\_\_\_\_\_NO\_\_\_\_\_\_\_\_\_\_**

**MEDICATION**

**Which Pharmacy do you use? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Town and telephone of your pharmacy \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**What medications (including non-prescription) do you use? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please check any of the medical problems that apply to you:**

**Asthma\_\_\_ Anemia\_\_\_ Arthritis\_\_\_ Blood Clots\_\_\_ Cancer\_\_\_ Diabetes\_\_\_**

**Delayed Healing\_\_\_ Circulation Problems\_\_\_ Heart Condition\_\_\_ Hepatitis\_\_\_**

**Gout\_\_\_ Heart Attack\_\_\_ High Blood Pressure\_\_\_ HIV\_\_\_ Hormones\_\_\_ Infections\_\_\_ Kidney Dysfunction\_\_\_ Liver Problems\_\_\_ Neurological Disorder\_\_\_ Parkinson’s\_\_\_ Rheumatic Fever\_\_\_ Skin Problems\_\_\_ Stomach Ulcer\_\_\_ Stroke\_\_\_ Tuberculosis\_\_\_ Unexplained weight loss/ gain\_\_\_**

**PODIATRIC HISTORY**

**Check if there is a family (blood relative) history of:**

**Heart Disease\_\_\_ Arthritis\_\_\_ Bleeding Disorder\_\_\_ Bunions\_\_\_ Diabetes\_\_\_ Stroke\_\_ Circulation Problems\_\_\_ Flat Feet\_\_\_ Hammer Toes\_\_\_**

**Neurological Disorder\_\_\_**

**Check any of the following problems that apply to you:**

**Ankle Pain\_\_\_ Athletes Foot\_\_\_ Bunions\_\_\_ Corns/ Calluses\_\_\_ Flat Feet\_\_\_**

**Fungus\_\_\_ Hammertoes\_\_\_ Heel Pain\_\_\_ Ingrown Toenails\_\_\_ Warts\_\_\_**

**Numbness/ Cramps in legs or feet\_\_\_ Swollen feet\_\_\_ Tired Feet\_\_\_**

**Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Are you allergic or sensitive to any of the following?**

**Adhesive tape\_\_\_ Penicillin\_\_\_ Coumadin\_\_\_ Aspirin\_\_\_ Latex\_\_\_ Codeine\_\_\_**

**Iodine\_\_\_ Local Anesthetics\_\_\_ Novocain\_\_\_ Seafood\_\_\_**

**Other foods or medicine\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Do you have an artificial joint? (Hip, knees, etc) YES\_\_\_\_ NO\_\_\_\_**

**If yes describe\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Do you have a Heart Valve Implant? YES\_\_\_\_\_ NO\_\_\_\_\_**

**Do you smoke? YES\_\_\_\_ NO\_\_\_\_ If yes, how many per day? \_\_\_\_ Number of years? \_\_\_**

**Previously smoked? YES\_\_\_\_\_ NO\_\_\_\_\_ How long ago did you quit? \_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Do you drink alcohol or beer? YES\_\_\_\_\_ NO\_\_\_\_\_\_**

**Light usage\_\_\_\_ Moderate (1-2 per day) \_\_\_\_\_Heavy (more than 2 per day)** \_\_\_\_\_

**Occupation\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Describe your routine at work:**

**Sit at job\_\_\_\_\_\_\_\_ Stand at job\_\_\_\_\_\_\_\_\_ Stand and walk at job\_\_\_\_\_\_\_\_\_\_\_\_\_**

**We thank you for taking the time to complete this medical history form. This helps us to make the best decisions concerning your medical care.**

*I understand that all of the above and hereby state that the information is correct and accurate to the best of my knowledge*

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Patient Signature/ Legal Guardian Date**

**New Haven Foot & Ankle Group Inc.**

**136 Sherman Avenue Suite 202**

**New Haven CT 06511**

**203-745-3400**

**ACKNOWLEDGEMENT OF RECEIPT**

**OF**

**NOTICE OF PRIVACY PRACTICES**

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read if I chose) and understand the Notice.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Name (please print) Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent or Authorization Representative (if applicable)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature