Alaska Foot & Ankle Specialists

PATIENT

Name: _____ (LAST) _____ (FIRST) _____ (Middle Initial)

Date of Birth: _____ Sex/Gender: _____

Mailing Address: _____

Soc. Security #: _____

_____ (CITY) _____ (STATE) _____ (ZIP CODE)

Phone #s *Check the best way to reach you* ☑ — What type of **message** can we leave? Detailed / General

Email: _____

Cell: _____ ☐ ☐ ☐

Occupation: _____

Home: _____ ☐ ☐ ☐

Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Work: _____ ☐ ☐ ☐

Who Referred You? _____

☐ **Emergency Contact:** ☐ Privacy & Communication

Name: _____

Phone #s: _____

Relationship to Patient: _____

If Parent/Guardian/Responsible Party ↓

Soc. Security #: _____

☐ **Emergency Contact:** ☐ Privacy & Communication

Name: _____

Phone #s: _____

Relationship to Patient: _____

If Parent/Guardian/Responsible Party ↓

Soc. Security #: _____

PRIMARY INSURANCE

Insurance Company: _____

Subscriber ID: _____

Policy Holder: ☐ Self ☐ Spouse ☐ Parent ☐ Other

Group ID: _____

Policy Holder Name: _____

Date of Birth: _____

SECONDARY INSURANCE

Insurance Company: _____

Subscriber ID: _____

Policy Holder: ☐ Self ☐ Spouse ☐ Parent ☐ Other

Group ID: _____

Policy Holder Name: _____

Date of Birth: _____

Please understand that insurance is billed as a courtesy.

Protected health information may be disclosed to another covered entity for select health care operations, such as: payment activities, treatment quality assessment activities and other purposes. I have been offered a copy of the Notice of Privacy Policy. I understand the organized health care arrangement has the right to change this notice at any time and I may obtain a current copy by contacting this office. I understand that I am responsible for any amount not covered by insurance.

By signing below, I authorize the Practice to release any information acquired in the course of treatment necessary to process insurance claims and I authorize payment directly to the Physician. **I also understand that I am ultimately responsible for all charges, regardless of insurance coverage.**

_____ Responsible Party Signature

_____ Date

Today's Date: _____

Patient Name: (Last, First, MI) _____ Shoe Size _____ **Date of Birth:** _____ Age: _____

Gender: _____ Height: _____ Weight: _____ **Marital Status:** ☐ Single ☐ Married ☐ Divorced ☐ Widowed **Race:** _____ *(optional)*

Home City/State: _____ **Occupation/School:** _____

Referring Physician: *(If applicable)* _____ **Primary Care Physician:** _____

What would you like to be seen for today? (Please be detailed): _____

Have you ever seen other providers for foot/ankle problems? If so, please provide their information below.

Physician _____ Address: _____

Physician _____ Address: _____

Do you see any specialists? ☐ No ☐ Yes *If "yes",* please provide names & phone numbers ↓

_____

Habits

Exercise: ☐ No ☐ Yes →How much? How often? What kind? _____

Tobacco Use: ☐ No ☐ Yes →How much? How often? For how long? _____

Stopped/Quit ☐ No ☐ Yes →When? _____

Alcohol Use: ☐ No ☐ Yes →How much? How often? For how long? _____

Marijuana Use: ☐ No ☐ Yes →How much? How often? For how long? _____

Social/Family

Any pertinent social or family history relative to your clinical situation? ☐ No ☐ Yes _____

Is there a family history of diabetes? ☐ No ☐ Yes Relationship to you: _____

What medical problems run in your family? *1* _____ *2* _____ *3* _____

Relationship to you: _____ _____ _____

Allergies

Mark allergies *or* indicate no allergies here

	Reaction		Reaction		Reaction
☐ Adhesive/Tape		☐ Latex		☐ Penicillin	
☐ Aspirin		☐ Local Anesthetics		☐ Seafood	
☐ Codeine		☐ Metals *(Nickel, etc.)*		☐ Sulfa	
☐ Demerol		☐ Methylparabens		☐ *Other*	
☐ Dye/Iodine		☐ NSAIDs		☐ *Other*	

→→→→→→ ☐ **I have no known allergies**

Medication

Do you take: Oral Contraceptives? ☐ No ☐ Yes Blood Thinners? ☐ No ☐ Yes

Please list **ALL** medications *and/or* supplements you take ***or attach a list***

Medication Name	Strength	How Much	How Often	**Medication Name**	Strength	How Much	How Often
Example	*25mg*	*2*	*twice a day*				

☐ **I take no medications**

Please continue to 2nd page

Today's Date: _____

Patient Name: (Last, First, MI) _____ **Date of Birth:** _____

Previous Operations

Operation	Date	Comments/Details:	Operation	Date	Comments/Details:
☐ Fracture Repair			☐ Joint Arthroscopy/Replacement		
☐ Heart/Vascular			☐ Other		

Review of Systems

Please check "**yes**" or "**no**" to indicate if **you** have the following:

☐ No ☐ Yes Black Stools or GI Bleeding
☐ No ☐ Yes Bleeding or Bruising
☐ No ☐ Yes Chest Pain/Palpitations
☐ No ☐ Yes Fever or Chills
☐ No ☐ Yes Intolerance to NSAIDs
☐ No ☐ Yes Itching, Rashes or Scaly Skin
☐ No ☐ Yes Joint Pain/Stiffness
☐ No ☐ Yes Nausea, Vomiting, Diarrhea
☐ No ☐ Yes Numbness or Tingling
☐ No ☐ Yes Shortness of Breath
☐ No ☐ Yes Swelling of Ankles/Feet
☐ No ☐ Yes Unexplained Weight Change

Previous Foot/Ankle Problems

☐ No ☐ Yes Athlete's Foot
☐ No ☐ Yes Bunion
☐ No ☐ Yes Chronic Ankle Sprains
☐ No ☐ Yes Chronic Calluses
☐ No ☐ Yes Diabetic Wounds
☐ No ☐ Yes Hammertoes
☐ No ☐ Yes Plantar Fasciitis
☐ No ☐ Yes Toenail Problems

Medical Conditions

Please check "**yes**" or "**no**" to indicate if **you** have a history of the following conditions:

☐ No ☐ Yes AIDS/HIV
☐ No ☐ Yes Anemia
☐ No ☐ Yes Arthritis
☐ No ☐ Yes Back Problems
☐ No ☐ Yes Bladder/Urinary Problems
☐ No ☐ Yes Bleeding/Clotting Disorder
Details: _____
☐ No ☐ Yes Breathing/Respiratory Issues
☐ No ☐ Yes Cancer
Details: _____
☐ No ☐ Yes Chemical/Drug Dependence
☐ No ☐ Yes Chronic Fatigue Syndrome *or* Fibromyalgia
☐ No ☐ Yes Chronic Infections
☐ No ☐ Yes Circulation/Vascular Problems
☐ No ☐ Yes Degenerative Muscle Disease
☐ No ☐ Yes Diabetes Last A_1C: _____
☐ Type 1 ☐ Type 2 Taking insulin? Yes / No
☐ No ☐ Yes Digestive Issues
☐ Colitis ☐ GERD ☐ IBS
☐ No ☐ Yes Ear Problems
☐ No ☐ Yes Epilepsy
☐ No ☐ Yes Eye/Vision Problems
☐ No ☐ Yes Fainting
☐ No ☐ Yes Foot/Leg Cramps
☐ No ☐ Yes Gout
☐ No ☐ Yes Headaches/Migraines
☐ No ☐ Yes Heart Disease
Details: _____
Pacemaker/Defibrillator? ☐ Yes ☐ No
Stents? ☐ Yes ☐ No
☐ No ☐ Yes Hepatitis
Type: _____ Active? ☐ Yes ☐ No
☐ No ☐ Yes Hernia
☐ No ☐ Yes High (or Low) Blood Pressure
☐ No ☐ Yes Hormone Disorder
☐ No ☐ Yes Implants/Prosthetics
Details: _____
☐ No ☐ Yes Joint Concerns
☐ No ☐ Yes Kidney Issues
Details: _____
☐ No ☐ Yes Liver Disease *(other than hepatitis)*
☐ No ☐ Yes Lupus
☐ No ☐ Yes MRSA History
☐ No ☐ Yes Multiple Sclerosis
☐ No ☐ Yes Nerve Disease
☐ No ☐ Yes Neuropathy
☐ No ☐ Yes Parkinson's
☐ No ☐ Yes Polio
☐ No ☐ Yes PTSD
☐ No ☐ Yes Raynaud's Disease
☐ No ☐ Yes Rheumatic Fever
☐ No ☐ Yes Rheumatoid Arthritis
☐ No ☐ Yes Sexually Transmitted Disease
☐ No ☐ Yes Stroke/TIA
☐ No ☐ Yes Thyroid Disease
☐ No ☐ Yes Weight Issues

☐ ***Other*** Medical Condition(s) _____

Preferred Pharmacy: _____ Phone: _____

I certify that the above information is true and correct to the best of my knowledge. I give my permission **for Alaska Foot and Ankle Specialists** to administer and perform such procedures as deemed necessary for diagnosis and/or treatment.

_____ _____
Signature of patient *(or responsible party)* Date

_____
Responsible Party Name *(if not signed by the patient)*