

Patient Registration

NEO Foot & Ankle Surgical Associates, Inc

1 PATIENT INFORMATION

TODAY'S DATE _____

PATIENT'S LAST NAME _____ FIRST _____ MIDDLE INITIAL _____

MAILING ADDRESS _____ APT NO _____

CITY _____ STATE _____ ZIP CODE _____

HOME PHONE: _____ CELL PHONE: _____

PATIENT E-MAIL ADDRESS _____

SEX: MALE: _____ FEMALE: _____ AGE: _____ DATE OF BIRTH _____ SS# _____

HEIGHT _____ WEIGHT _____ SHOE SIZE _____ HOSPITAL OF CHOICE: _____

MARITAL STATUS: Single _____ Married _____ Widowed _____ Separated _____ Divorced _____

OCCUPATION _____ EMPLOYER _____

EMPLOYER ADDRESS _____ EMPLOYER PHONE: _____

SPOUSE'S NAME _____

NAME OF PARENT OR GUARDIAN (IF PATIENT IS A MINOR) _____

PARENT/GUARDIAN SS# _____ PARENT/GUARDIAN DATE OF BIRTH _____

2 REFERRAL INFORMATION – HOW DID YOU FIND OUT ABOUT US?

_____ FAMILY MEMBER/FRIEND and NAME _____ DR. _____

_____ PHONE BOOK/YELLOW PAGE _____ INTERNET/WEB SITE _____ INSURANCE BOOK _____ HOSPITAL _____

3 INSURANCE ****PLEASE PRESENT YOUR INSURANCE CARD & DRIVER'S LICENSE TO THE RECEPTIONIST.**

PRIMARY INSURANCE INFORMATION:

LAST NAME OF INSURED _____ FIRST NAME _____ MIDDLE INITIAL _____

RELATIONSHIP TO PATIENT _____

INSURED'S SS# _____ INSURED'S DATE OF BIRTH _____

Will not be seen if this information is missing.

SECONDARY INSURANCE INFORMATION:

LAST NAME OF INSURED _____ FIRST NAME _____ MIDDLE INITIAL _____

RELATIONSHIP TO PATIENT _____

INSURED'S SS# _____ INSURED'S DATE OF BIRTH _____

Will not be seen if this information is missing.

TERTIARY INSURANCE INFORMATION:

LAST NAME OF INSURED _____ FIRST NAME _____ MIDDLE INITIAL _____

RELATIONSHIP TO PATIENT _____

INSURED'S SS# _____ INSURED'S DATE OF BIRTH _____

Will not be seen if this information is missing.

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4 CHIEF COMPLAINT: What is the chief complaint for which you came to be treated? (Include foot, ankle, knee, thigh, and hip complaints.) _____

5 PATIENTS HISTORY OF PRESENT ILLNESS (WHY YOU ARE HERE):

(OKAY TO CIRCLE)

Nature of your pain:	Sharp,	Burning,	Dull Ache,	Electrical Shooting	Other: _____				
Location of Problem:	Foot	Leg	Ankle	Toes	Other: _____				
Duration: (How long)	1	2	3	4	5	6	Days	Weeks	Months
Onset: (How did it start)	Gradual	Sudden	Trauma	Other: _____					
Characteristics:	Mild	Moderate	Severe	Other: _____					

Alleviating Factors: (What makes the pain **better**?)

Bracing Cold Exercise
 Heat Immobilization Lying Down
 Sitting Standing Stretching
 Walking Pain Medicine: _____

Aggravating Factors: (What makes the pain **worse**?)

Bracing Cold Exercise
 Heat Immobilization Lying Down
 Sitting Standing Stretching
 Walking Pain Medicine: _____

Treatment:

Acupuncture Anti-inflammatory Medications Biofeedback Biofreeze Bracing Chiropractor
 Cortisone Massage Nerve Block Orthotics PT Surgery Tens Unit
 R.I.C.E. Therapy (Rest, Ice, Compression, Elevation) Any other treatment options: _____

Work Related Injuring:

Is this a work-related injury? Yes No What is the date of the injury? _____

Where did the injury occur? _____

If the injury occurred at work, has your employer been notified? Yes No

Have you filed a "Report of First Injury" ? YES ? NO

Employer _____ Occupation _____

Employer Phone # _____ Contact Person _____

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6 MEDICAL HISTORY – Please indicate problems you now have or have had in the past.

GENERAL

- Aids/HIV
- Depression
- Dizziness
- Fever
- Forgetfulness
- Headache/Migraine
- Loss of Sleep
- Loss of Weight
- Numbness
- Sweats / Chills

MUSCLE/JOINT

- Ankle Pain
- Achilles Tendon Pain
- Arthritis
 - Gout
 - Osteoarthritis
 - Rheumatoid
- Foot Pain
- Heel Pain
- Knee Pain

GENITO-URINARY

- Blood in Urine
- Frequent Urination
- Incontinence
- Kidney Problems
- Painful Urination

PSYCHIATRIC

- Anxiety
- Bi-Polar
- Chemical Dependency
- Depression
- Panic Attacks
- Psychiatric Care
- Schizophrenia

GASTROINTESTINAL

- Bloating or Gas
- Bowel Changes
- Constipation/Diarrhea
- Excessive Thirst
- Hepatitis or Jaundice
- Hemorrhoids
- Liver Problems
- Nausea
- Poor Appetite
- Rectal Bleeding
- Stomach pain/Reflux
- Ulcers/Diverticulitis
- Vomiting/Vomiting Blood

CARDIOVASCULAR

- Blood Clots (DVT)/(PE)
- CAD
- Chest Pain
- CHF
- Cramping in Legs/Feet
- Heart Attack (MI)
- High/Low Blood Pressure
- High Cholesterol
- Phlebitis
- Poor Circulation
- Irregular/Rapid Heart Beat
- Stroke
- Swelling of Ankles
- Varicose Veins

CANCER

- Type: _____
- Treatment
- Chemotherapy
- Herbal
- Radiation
- Surgical

EARS, NOSE, THROAT

- Bleeding Gums
- Blurred Vision
- Difficulty Swallowing
- Earache/Ear discharge
- Hay Fever
- Hoarseness
- Loss of Hearing
- Nosebleeds
- Persistent Cough
- Ringing in ears
- Sinus Problems

SKIN

- Bruises Easily
- Change in Moles
- Eczema
- Psoriasis
- Rash/Itching/Hives
- Scars
- Sores that will not heal

RESPIRATORY

- Asthma
- Bronchitis
- Dizziness
 - Emphysema /COPD
- Pneumonia
- Shortness of Breath
- Sleep Apnea
- Tuberculosis (TB)

EYES

- Blurred Vision/Cataracts
- Corrective Lens
- Double Vision
- Halos/Flashes
- Glaucoma

MEN ONLY

- Erection Difficulties
- Venereal Disease
- Other: _____

WOMEN ONLY

- Other: _____
- Venereal Disease

ENDOCRINE

- Diabetes
 - Pills
 - Insulin
- Thyroid
 - Overactive
 - Underactive

PODIATRY HISTORY

- Bunions
- Corns & Calluses
- Flat Feet
- Ingrown Toenails
- Plantar's Warts

NEUROLOGIC

- Dementia/Alzheimer's
- Fainting
- Headaches
- Neuropathy
- Seizures or Epilepsy
- Sciatica

HEMATOLOGICAL

- Anemia
- Hemophilia
- Swollen Glands
- Other: _____

Are you now, or have you been, under any other doctor's care for any reason over the past two years?

- Yes No Doctor Name: _____ Number: _____ Reason: _____
- Yes No Doctor Name: _____ Number: _____ Reason: _____
- Yes No Doctor Name: _____ Number: _____ Reason: _____
- Yes No Doctor Name: _____ Number: _____ Reason: _____
- Yes No Doctor Name: _____ Number: _____ Reason: _____

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7 MEDICATIONS – Please list all medications from all physicians.

ARE YOU CURRENTLY ACCEPTING PAIN/NARCOTIC MEDICATIONS FROM ANY OTHER SOURCE:

NO YES **NAME OF PHYSICIAN/SOURCE:** _____ **NUMBER:** _____

If you are accepting narcotics from another source and do not disclose it, you will be released from this practice.

Antidepressants: Elavil Amitryptilline Prozac Effexor Zoloft Deseryl
Serozone Desipramine Remeron Pamelor Paxil Other: _____

Blood Thinners: Aspirin Coumadin (Warfarin) Fragmin (Dalteparin) Garlic Pills Heparin Lovenox (Enoxaparin)
Plavix Any other blood thinners: _____

Diabetic Medication: Glyburide Glipzide Glimperide Metformin Precose Avandia Actos Starlix Prandin
Januvia Byetta Novolin N Levemir Lantus Novolin 70/30 Novolin R Novolog Other: _____

Narcotics: Darvocet Vicodin Percocet Demerol Dilaudid Morphine
MS Contin Oxycontin Tylox Tylenol 3 Methadone Other: _____

Neuropathic Pain Medications: Neurontin Klonopin Tegretol Dilantin
Ultram Prozacin Mexitil Prazocin Other: _____

NSAIDS: Aspirin Ibuprofen Advil Motrin Naprosyn Mobic Aleve Celebrex Other: _____

Relaxants: Ativan Baclofen Flexeril Librium Paxil Valium Xanax Other: _____

Sleep Medicines: Ambien Restoril Benedryl Halcion Other: _____

Medication: _____ Dose: _____ Medication: _____ Dose: _____

Medication: _____ Dose: _____ Medication: _____ Dose: _____

Medication: _____ Dose: _____ Medication: _____ Dose: _____

Do you take oral contraceptives? Yes No

Preferred Pharmacy Name _____ Pharmacy Phone # _____

8 ALLERGIES – Mark any that apply:

No Known Allergies	<input type="checkbox"/>				
Adhesive Tape	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Latex	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Anti-Inflammatory Meds	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Local Anesthetics	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Anticoagulant Therapy	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Novacaine	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Aspirin	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Penicillin	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Codeine	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Seafood	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Cortisone	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Sulfa	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Demerol	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Other	<input type="checkbox"/> Yes	<input type="checkbox"/> No

REACTION: _____

REACTION: _____

REACTION: _____

9 PAST SURGICAL HISTORY

Please list surgeries:

Surgery _____ Date _____

Surgery _____ Date _____

Surgery _____ Date _____

Surgery _____ Date _____

Surgery _____ Date _____

Hospitalizations other than for surgeries listed _____

Family Physician _____ Date of last visit _____

Address _____ Phone # _____

10 SOCIAL HISTORY

Alcohol Use: Drinks per day _____ Other Drug Use: _____ Tobacco Use: YES NO Years Smoked _____

Occupation: _____ Employment Status: _____

Marital Status: Single Married Divorced Widowed Separated

Athletic activities in which you participate _____

11 FAMILY HISTORY

Mother: Living
Deceased Cause: _____
History Of: Diabetes High Blood Pressure Thyroid Problems Cancer: _____

Father: Living
Deceased Cause: _____
History Of: Diabetes High Blood Pressure Thyroid Problems Cancer: _____

Siblings: Living **Brother** **Sister**
Deceased Cause: _____
History Of: Diabetes High Blood Pressure Thyroid Problems Cancer: _____

Siblings: Living **Brother** **Sister**
Deceased Cause: _____
History Of: Diabetes High Blood Pressure Thyroid Problems Cancer: _____

Siblings: Living **Brother** **Sister**
Deceased Cause: _____
History Of: Diabetes High Blood Pressure Thyroid Problems Cancer: _____

Siblings: Living **Brother** **Sister**
Deceased Cause: _____
History Of: Diabetes High Blood Pressure Thyroid Problems Cancer: _____

SIGNATURE ON FILE & PERMISSION TO TREAT

I request that payments of authorized benefits on my behalf for any services furnished me by Northeastern Ohio Foot & Ankle Surgical Associates, Inc. I authorize any holder of information about me to release any information needed to determine these benefits or the benefits payable to related services to the insurance agent. I recognize my financial obligation of any co-insurance, co-pays, or deductibles and non-covered services that may be required. I give permission to Northeastern Ohio Foot & Ankle Surgical Associates, Inc. to examine, photograph, administer, and perform such minor operative procedures as may be deemed necessary in the diagnosis and/or treatment of my foot and/or ankle problems.

Signed _____ Date _____

PRIVACY STATEMENT

Northeastern Ohio Foot & Ankle Surgical Associates, Inc. will use and disclose your health information for the following purposes: to treat you, to assist other health care providers in treating you, to allow insurance companies to process insurance claims for services rendered to you, to obtain payment for services rendered to you and for certain limited operation activities, such as quality assessment, licensing, accreditation and training of students. Except as stated in more detail in the Notice of Privacy Practices, we will not use or disclose your health information without your written authorization. If you have any questions, concerns, or complaints regarding our privacy practices, please refer to the actual Notice of Privacy Practices provided to you for the person(s) whom you may contact.

Additional Disclosure Authority: In addition to the allowable disclosures described in the State of Privacy Practices, I hereby specifically authorize disclosure of my protected health care information to the persons indicated below.

- ANY MEMBER OF MY IMMEDIATE FAMILY YES NO
- SPOUSE ONLY YES NO
- OTHER (PLEASE SPECIFY) _____ YES NO

Acknowledgement of Receipt of Notice of Privacy Practices:
(Signature represents that I have been offered a copy of the policy)

Patient or Authorized Representative's Initials

Date

Revised 03/10