PATIENT INFORMATION

Name: _____

Date of Birth: _____ Age: _____ Gender: _____

Height: _____ Weight: _____ Shoe Size: _____

Street Address: _____

Mailing Address (if different): _____

Home Phone: ( ) _____ Cell Phone: ( ) _____

Email: _____ **We use email to confirm future appts**

Occupation: _____

Social Security Number: _____

Pharmacy Name: _____

Pharmacy Location: _____

Race: (circle one) American Indian Alaskan Native Asian Native Hawaiian
Black/African American White Hispanic Other: _____

Ethnicity: Hispanic _____ Non-Hispanic _____

Marital Status: Single _____ Married _____ Divorced/Separated _____ Widowed _____

Spouse's Name (if applicable) _____

INSURANCE INFORMATION (Fill out if insurance cards were **NOT** provided at the time of your visit)

Primary Insurance Co: _____ Insured's Name: _____

Insured's SS#: _____ Insured's Group #: _____

Secondary Insurance Co: _____ Insured's Name: _____

Insured's SS#: _____ Insured's Groups #: _____

BACKGROUND INFORMATION

Family Doctor/PCP: _____

Last visit date (approximately) _____

How did you hear about our office? _____

Please describe your present foot/ankle problem(s): _____

Any previous treatment(s): _____

PATIENT NAME: _____

MEDICAL HISTORY

Check any of the following medical conditions that you now have, or have had in the past:

	AIDS/HIV		Blood Clot		Problem with Walking/Gait
	Anemia		Diabetes		Rheumatoid Arthritis
	Problems with Anesthesia		How long? Insulin: Y or N		Sexually Transmitted Disease
	Arthritis		Gout		Stomach Ulcers
	Cancer		Heart Attack/MI		Stroke
	Type:		Hepatitis		Swelling of Feet/Ankles
	Chronic Kidney Disease		High Blood Pressure		Thyroid Problems
	Circulation Problems		High Cholesterol		Tuberculosis
	Congestive Heart Failure		Liver Disease		Varicose Veins
	COPD/Asthma/Emphysema		Muscular Disorder		Wound Healing Problems

Any other medical conditions/diagnosis: _____

ALLERGIES

Please check any medical/drug allergies you may have:

	NO KNOWN ALLERGIES		Sulfa
	Adhesives		Local Anesthetics
	Codeine		Penicillin
	Iodine		Other: (Please Specify)

MEDICATION AND DOSAGE **(If you brought a list, please attach)**

	Medication	Strength (mg)	# of pills per day
1.			
2.			
3.			
4.			
5.			

ORTHOPEDIC SURGERIES

Please check any surgeries you may have had in the past:

- ☐ Appendix
- ☐ CABG/Stents
- ☐ Gallbladder Surgery
- ☐ Hernia Repair
- ☐ Hip Repair/Replacement Right _____ Left _____
- ☐ Knee Replacement Right _____ Left _____
- ☐ Foot Surgery Right _____ Left _____

What kind of procedure(s): _____

_____

Any problem with general or local anesthesia? ☐ Yes ☐ No Describe: _____

PATIENT NAME: _____

SOCIAL HISTORY

Do you drink Alcohol? ☐ Yes ☐ No

If yes, how often? ☐ Socially ☐ Occasionally (1-2/wk) ☐ Regularly (3-5+/week)

Do you smoke or use Tobacco products? ☐ Yes ☐ No ☐ Former Smoker

If yes, for how long? _____

If former smoker, what year did you quit? _____

Packs smoked per day: ☐ < ½ ☐ ½ ☐ 1 ☐ 2 ☐ >2

FAMILY HISTORY

List any blood relatives with a history of:

☐ Blood clots/excessive bleeding	Relationship: _____
☐ Adverse reaction to anesthesia	Relationship: _____
☐ Cardiac disorders	Relationship: _____
☐ Cancer	Relationship: _____
☐ Diabetes	Relationship: _____
☐ Auto-immune Disorders	Relationship: _____

I hereby give The Ridge Foot and Ankle Center **permission to examine and administer treatment, after consultation, and perform such procedures as may be deemed necessary in the diagnosis and/or treatment of my foot or ankle condition. I also assign to** The Ridge Foot and Ankle Center **all payment for medical services rendered to myself or my dependent. I understand that I am responsible for any amount not covered by my insurance carrier. I also authorize release of medical information necessary to process any health insurance claims or for referral to other specialties. A copy of my signature on file will be considered as valid as the original.**

_____ _____

Signature of Patient/Parent/Guardian Date

CONSENT OF CARE:

I hereby give my consent for treatment to The Ridge Foot and Ankle Center, Dr. Braden Jenkins, DPM for services. These may include, but are not limited to: examination, x-rays, injections, photos, and treatments which my physician and I agree are necessary.

AUTHORIZATION TO OBTAIN/RELEASE MEDICAL RECORDS:

I authorizeThe Ridge Foot and Ankle Center , or any person designated by them to obtain/release copies of my medical records to any physician or institution for the purpose of evaluation and/or comparison with examination and testing being performed on me/my dependent.

AUTHORIZATION TO PAY BENEFITS TO PHYSICIANS:

I hereby authorize payment toThe Ridge Foot and Ankle Center for services rendered to me or my dependent. I also authorize this office to release any information necessary to expedite insurance claims. To the extent permitted by law, I authorize holder to release information to CMS and applicable government agencies regarding determining benefits for service. I understand that I am responsible for any balance not covered by insurance and/or collection costs and legal fees incurred in any attempt to collect said balance. I assign all medical and surgical benefits to Valley Foot & Ankle Specialists.

PATIENT HIPPA ACKNOWLEDGEMENT AND DESIGNATION:

I have been given an opportunity to read the Health Information Portability & Accountability Act of 19996 (HIPPA)

I hereby authorize The Ridge Foot and Ankle Center to leave messages regarding pending appointments and/or lab or diagnostic results at my residence or via voice mail. You may notify me through (check all that apply)

☐ Cell Phone ☐ Home Phone ☐ Spouse ☐ Family/Friend

_____

Please specify name of designated person(s)

Please acknowledge that you have read and agree to all the above statements by signing below

Patient's Name (please print): _____

Signature of Patient/Parent/Guardian: _____ Date: _____