OHIO
FOOT & ANKLE
SPECIALISTS
PREMIER PODIATRIC CARE

PATIENT DEMOGRAPHICS

Patient's Name: _____ Today's Date: _____
Address: _____
City, State & Zip Code: _____
Social Security Number: _____ Home Phone: _____
Cell Phone: _____ Cell Phone Carrier: _____
Email Address: _____ Date of Birth: _____
Race: _____ Ethnicity (Check One): ☐ HISPANIC ☐ LATINO ☐ NOT HISPANIC OR LATINO
Primary Language: ☐ English ☐ Spanish ☐ German ☐ Russian ☐ Other: _____
Pharmacy: _____ Phone #: _____
Pharmacy Address: _____
If Referred, Name of the Person/Physician/Advertisement Referring: _____
Primary Care Physician (PCP): _____ PCP Date of Last Visit: _____
Diabetic Physician: _____ Date of Last Visit: _____
Emergency Contact: _____ Phone #: _____ Relationship: _____

PRIMARY INSURANCE INFORMATION
Name of Insurance: _____
Policy Holder: _____
Relationship: _____
Date of Birth: _____

SECONDARY INSURANCE INFORMATION
Name of Insurance: _____
Policy Holder: _____
Relationship: _____
Date of Birth: _____

REASON FOR TODAY'S VISIT

Describe Your Foot/Ankle Problem: _____
Where Is the Pain/Problem Located: _____
How Long Has It Been Bothering You: ____ Days ____ Weeks ____ Months ____ Years
How Severe Is the Pain/Problem: ☐ Mild ☐ Moderate ☐ Severe Are You in Hospice: ☐ No ☐ Yes
Is This a Work-Related Injury: ☐ No ☐ Yes If Yes, When Was the Date of Injury: _____
List Your Current Height: ____ Weight: ____ Shoe Size: ____ Are You Pregnant: ☐ No ☐ Yes

MEDICAL HISTORY (CHECK ALL THAT APPLY TO YOU)

☐ No Current Problems	☐ Anemia/Clotting Disorder	☐ Arthritis
☐ Asthma	☐ Bladder Infection	☐ Bleeding Disorder
☐ Anxiety/Depression	☐ Fibromyalgia	☐ Gout
☐ HIV Infection/AIDS	☐ Heart Problems/Attack	☐ Hepatitis
☐ High Blood Pressure	☐ Kidney Disease	☐ Liver Disease
☐ Sickle Cell Anemia	☐ Stroke	☐ Thyroid Disease
☐ Alzheimer's/Dementia	☐ Cancer	☐ Parkinsons Disease

☐ Neuropathy	☐ Tuberculosis	☐ Bipolar Disorder
☐ Diabetes	☐ History of Drug/Alcohol Abuse	☐ Other:

PRIOR SURGERIES/HOSPITALIZATIONS:	☐ No Prior Surgeries/Hospitalizations

MEDICATIONS:	☐ No Current Medications

ALLERGIES:	☐ No Known Drug Allergies

FAMILY HISTORY (CHECK ALL THAT APPLY)

☐ Neuropathy	☐ Stroke	☐ Heart Attack	☐ Heart Disease
☐ High Blood Pressure	☐ Heart Murmur	☐ Cardiac Arrhythmia	☐ Cholesterol Disease
☐ Circulation Disease	☐ Diabetes	☐ Kidney Disease	☐ COPD/Emphysema
☐ Asthma	☐ Ulcer/GERD	☐ Bleeding Disorder	☐ Anemia
☐ Hepatitis A / B / C	☐ HIV / AIDS	☐ Osteoporosis	☐ Fibromyalgia
☐ Arthritis	☐ Gout	☐ Mental Illness	☐ Depression
☐ Thyroid Disease	☐ Alzheimer's	☐ Cancer	☐ Frequent Infections
☐ Tuberculosis	☐ Parkinson's	☐ Clotting Disorder	☐ Other:

SOCIAL HISTORY (FILL OUT COMPLETELY)

Do You Smoke: ☐ No ☐ Former Smoker (Quit date: _____) ☐ Yes Packs Per Day: _____

Do You Drink Alcohol: ☐ No ☐ Yes How Much Do You Drink: ☐ Light ☐ Moderate ☐ Heavy

Do You Use Recreational Drugs: ☐ No ☐ Yes If Yes, What Do You Use: _____

Have You Fallen in the Past Year: ☐ No ☐ Yes How Many Times: _____ Injury: ☐ No ☐ Yes

AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

This form is for use when such authorization is required and complies with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Standards.

I authorize Ohio Foot & Ankle Specialists (OFAS) and its agents to release my health information for the purpose of payment, treatment and healthcare operations to any of the following: Insurance company and its affiliates, any practitioner, support staff or faculty involved in my plan of care or transfer of care. In addition, I understand that the potential uses and disclosures of my health information are detailed in the privacy policy. The HIPAA notice of privacy practices is available in the office. I have read and/or had the opportunity to read my HIPAA rights.

I designate OFAS (and its agents) as my authorized representative and authorize to act on my behalf to request and receive a copy of the summary plan description, to pursue a benefit claim, appeal an adverse benefit determination and/or file a legal action to recover benefits from my employee plan, insurance policy and third-party reimbursement or prepaid health plan. I understand and agree that my authorized representative shall have full authority to act and receive notices on my behalf with respect to an initial determination of a claim for health benefits relating to treatment and healthcare services received by me/ my child at OFAS, any requests for documents relating to the claims and adverse determination of the claims.

ACKNOWLEDGMENT OF RIGHTS:

- I understand that I have the right to revoke this authorization, in writing, at any time, except where uses or disclosures have already been made based upon my original permission. I might not be able to revoke this authorization if its purpose was to obtain insurance.
- I understand that uses and disclosures already made based upon my original permission cannot be taken back.
- I understand that Medical Records and information used or disclosed with my permission may be re-disclosed by a recipient and no longer protected by the HIPAA Privacy Standards.
- I understand that the treatment by any party may not be conditioned upon my signing of this authorization (unless treatment sought only to create Medical Records for a third party or to take part in a research study) and that I may have the right to refuse to sign this authorization.

<u>To the best of my knowledge, I have answered the questions on this form accurately. I understand that providing incorrect information can be dangerous to my health.</u>

Signature Date