MELBOURNE PODIATRY ASSOCIATES

Foot and Ankle Surgery

****PLEASE PRINT**

Name: (First)_____ (Last) _____ (MI)___ Age:___ Birthdate:_____

Home Phone: _____ Cell Phone: _____ Social Security No.: _____

Home Address: _____ City: _____ State:_____ Zip Code: _____

Permanent Address: _____ City: _____ State:_____ Zip Code: _____

Race: _____ Hispanic ☐ Non-Hispanic ☐ Preferred Language: _____

Single ☐ Married ☐ Widowed ☐ Divorced ☐ Email:_____

Name of Employer:_____ Work Phone:_____

Emergency Contact:_____ Relation: _____ Contact No.: _____

Address:_____ City: _____ State:_____ Zip Code: _____

How did you first learn about our office?_____

Pharmacy Name and Location:_____

RESPONSIBLE PARTY INFORMATION

Person responsible for payment (Or, if patient is a minor): _____

Employer:_____

Business Address: _____ Business Phone:_____

Is this a worker's comp claim? _____ Date of Injury: _____

HEALTH INSURANCE INFORMATION

Primary Insurance Company: _____

Primary Cardholder's Name:_____ Primary Cardholder's DOB: _____

ID Number: _____ Group Name: _____ Phone Number: _____

Address: _____

Secondary Insurance Company: _____

Primary Cardholder's Name:_____ Primary Cardholder's DOB: _____

ID Number:_____ Group Name: _____ Phone Number:_____

INSURANCE AUTHORIZATION AND ASSIGNMENT

INSURANCE RESPONSIBILITY/RELEASE OF INFORMATION: I understand and agree that regardless of my insurance status, I am financially responsible for the balance of my account. I acknowledge that I am responsible for any deductible, co-pay, or other balance not covered by my insurance carrier(s). Co-pays & deductibles are due at time of service. I hereby authorize any treatment(s), agreed upon with Dr. Richard Wilson, Dr. Jared Moyles, Dr. Thomas Wilson, or Dr. Jessica Wilson which may be deemed advisable. I hereby authorize payment directly to Melbourne Podiatry Associates for services. I understand that I must provide a legible copy of my insurance cares (with claims address and telephone number). I hereby authorize Melbourne Podiatry Associates to release full details of my medical history for the purposes of healthcare management and/or for processing all medical claims on my behalf. I authorize Melbourne Podiatry Associates to release any information acquired in the course of treatment necessary to process claims. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits to the party who accepts assignment. I also acknowledge that I have received the "Notice of Privacy Practices" for Melbourne Podiatry Associates.

PATIENT/GUARDIAN SIGNATURE:_____ **DATE:** _____

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Foot and Ankle Surgery

Welcome to our office! This information is important for our records and your treatment plan.
Please fill out this form as completely as possible. Thank you.

PLEASE CHECK ANY DISEASE, CONDITIONS OR SYMPTOMS THAT YOU CURRENTLY HAVE OR HAVE HAD IN THE PAST.

	YES	WHEN		YES	WHEN		YES	WHEN
Anemia			Heart surgery			Sleeping difficulty		
Artificial Valve			High blood pressure			Stomach trouble		
Back Pain			HIV+			Stomach ulcers		
Bad leg circulation			Impaired sight			Stroke		
Bleeding Disorder			Keloid scars			Thyroid		
Blood clot in leg			Kidney disease			Tingling		
Brain disease			Kidney stones			Varicose veins		
Bypass surgery legs			Leg cramps			Weakness		
Chemotherapy			Leg pain/walking			Weight gain (amt)		
Chest pain			Liver problems			Weight loss (amt)		
Cholesterol			Lung problems			Other		
Cold feet			Mental illness			Other		
Convulsions			Mitral valve prolapse			Other		
Depression			Muscle pain			Other		
Diabetes			Nausea			Other		
Diarrhea			Nervousness			Other		
Dizzy spells			Numbness			Other		
Excessive hunger			Osteoporosis			Other		
Excessive thirst			Prostate problems			Other		
Excessive urination			Psoriasis			Other		
Fainting spells			Rash			Other		
Feet swell			Rheumatic fever			Other		
Fibromyalgia			Rheumatoid arthritis			Other		
Foot ulceration			Sciatica			Other		
Fractures			Seizure			Other		
Gout			Sickle cell disease			Other		
Heart attack			Skin itching			Other		

Who is your primary care physician?_____

Did he/she refer you to our office today? (circle) **YES NO**

Last visit with Primary Physician?_____

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Foot and Ankle Surgery

Do you have diabetes? (circle) **Yes** or **No** If yes, for how long? _____

If yes, are you treated with: (circle) **oral medication** **insulin** **diet**

Treating Physician: _____ Average Blood Sugar: _____ Hemoglobin A1C: _____

Current Medication Dosage: _____

What is your main foot problem today? _____

_____

How severe is the pain or problem? (circle) **none** **minimal** **moderate** **severe**

How long have you had this problem? (circle) **1 2 3 4 5 6 7 8 9** **days** **weeks** **months** **years**

When is the problem worse? (circle) **first out of bed** **AM** **PM** **during/after work**

Other: _____

How would you describe the pain? (circle) **shooting burning** **aching** **throbbing** **bruised** **sharp** **dull** **itching** **tingling** **numbness** **tenders** **other:** _____

What make the pain better? _____

What caused the problem or makes it worse? _____

How has it been treated? (circle) **ice** **rest** **pads** **advil** **Tylenol** **Other:**

Do you have any other foot problems that need attention? _____

ALLERGIES: (circle) **No known drug allergies** **penicillin** **sulfa** **aspirin** **tape** **codeine** **iodine** **Novocain** **epinephrine** **other:** _____

_____

List all major surgeries or hospitalizations: _____

_____

List all major injuries: _____

_____

List all major illnesses: _____

_____

List all medications: _____

_____

_____

Do you have a family history of: (circle) **diabetes** **arthritis** **sickle cell** **cancer** **keloid scars** **heart or lung problems** **foot problems** **other:**

Which family member(s) were diagnosed? _____

_____

Do you smoke? (circle) **Never** **Former** **Current** If yes, how much per day? _____

Do you drink Alcocholic beverages? (circle) **Yes** **No** If yes, how much per week? _____

Do you exercise regularly? (circle) **Yes** **No** If yes, what type of exercise? _____

For Women: Number of Children? Are you, or could you be, pregnant? (circle) **Yes** **No**

If yes, number of months? _____

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Foot and Ankle Surgery

Emergency Contact Form/ HIPAA

In case of an emergency, who should we contact on your behalf?

1. _____ Relationship: _____ Ph:_____
2. _____ Relationship: _____ Ph:_____

Do you have a living will or advance directive? Yes __ No __

If yes, does this document specify any limitations for care in the event of any emergency (such as no blood products or transfusions, no intubation/ventilator, no CPR or resuscitation in the event of cardiac arrest)? If so, please document below and discuss these with your doctor. Yes __ No __

_____

If yes, does the document specify someone to have medical power of attorney (POA) for your affairs (i.e. someone designated to make decisions about your care and consent to procedures if you are unable to)?

Yes __No__ 3. Named POA: _____

Yes __No __ Has this individual actively assumed the role as your decision maker or POA?

Do you give our office and the doctors at Melbourne Podiatry Associates permission to discuss your medical condition and information about your care with any family members or close friends?

Yes __No __

If yes, please provide names and contact information below:

1. _____ Relationship: _____ Ph:_____
2. _____ Relationship: _____ Ph:_____

Patient Name: _____ POA Name: _____

_____ _____

Signature **Date**