Moore Foot & Ankle Specialists PA

PATIENT INFORMATION (Confidential Information – Important for our files and your health)

Patient Name: ____
Last First Middle

Date of Birth: __________ **Age**: ____ **Gender**: M / F **SSN #**: ____________ **Martial Status**: M / S / W / D **Race**: ________

Street Address: ____
Street City State Zip Code

Mailing Address: ____
(If different from above) Street City State Zip Code

Home Phone Number: ______________ **Cell Phone Number**: ______________ **Work Phone number**: ______________

Occupation: ______________________ **Patient Employed by**: ______________________

In Case of an Emergency Notify: ______________ **Relationship**: ______________ **Phone**: ______________

Parent / Guardian Information:

Name of Responsible Party: ______________________ **Relationship to Patient**: ______________

Date of Birth: ______________________ **Social Security #**: ______________________

Home Address: ____
Street City State Zip Code

Home Phone Number: ______________ **Cell Phone Number**: ______________ **Work Phone number**: ______________

Pharmacy Name: ______________________ **Pharmacy Phone Number**: ______________________

Insurance Information: (PLEASE PRESENT INSURANCE CARD (S) TO THE RECEPTIONIST)

1)______________________ 2) ______________________ 3) ______________________

How did you hear about our practice? ____

Financial Responsibility and Assignment of Insurance Benefits:

The undersigned guarantees payment to Moore Foot & Ankle Specialists, PA of all charges for services provided to the patient. I understand that I am personally responsible for all charges not covered by the insurance. I authorize direct payment of surgical and medical benefits, which would otherwise be payable to me, to Moore Foot & Ankle Specialists, PA for services rendered. If covered by Medicare or Medicaid. I certify that the information provided by me in applying for payment under title VXII and XIX of the Social Security Act is correct.

Authorization for Release of Medical Information:

The undersigned authorizes Moore Foot & Ankle Specialists, PA, Its physicians, practices or agents to disclose any medical information currently existing or developed during the course of treatment to: 1) the Social Security Administration or its intermediary, which may be needed for or related to Medicare or Medicaid claim; 2) state or federal agencies that provide benefits and require such information; 3) a referring physician or facility to which the patient my be referred; 4) third party payers or other involved in processing a claim for benefits for services rendered; 5) federal, state or local agencies as required to comply with the laws and regulations.

Authorization for Care and/or Treatment:

Knowing that I am suffering from a condition requiring health care treatment ("Treatment"), I voluntarily consent to such Treatment including diagnostic procedures and medical treatment ordered by my physician(s). I also voluntarily consent to Treatment provided by assistants, including medical and nursing students and/or other students in medically related fields, as judged necessary by my physician(s). I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me as the result of treatments or examinations by my caregivers. This form has been explained fully to me and I certify that I understand its contents. Consequently, I hereby release Moore Foot & Ankle Specialists, PA., its employees, and agents and representatives from such legal responsibilities regarding my knowledge of and consent to medical treatment and from such other legal responsibilities to the extent permitted by law.

______________________________________ ______________________
Patient / Guardian or Parent (If minor) Signature Date

Moore Foot & Ankle Specialists, PA

HISTORY & MEDICAL INFORMATION

Patient Name: ______________________ **Date:** ______________

1. Explain your foot/ankle problem ☐ Right ☐ Left : ______________________________

____

2. Describe the pain/discomfort: ☐ Burning ☐ Numbness ☐ Sharp ☐ Other: ______________

3. When did the pain/discomfort begin? ______________________________

4. Was the pain related to a trauma or injury? Please explain: ______________________________

5. What makes the pain/discomfort better? ______________________________

6. What makes the pain/discomfort worse? ______________________________

7. List all medications/herbs/vitamins: ☐ None ______________________________

____

8. Allergies and please describe reaction: ______________________________

9. Past Medical and Family History

Condition	Self	Family		Condition	Self	Family	
Anemia	☐	☐	________	Kidney Disease	☐	☐	________
Anesthetic Reaction	☐	☐	________	Liver Disease	☐	☐	________
Arthritis	☐	☐	________	Mental Retardation	☐	☐	________
Asthma	☐	☐	________	Mitral Valve Prolapse	☐	☐	________
Bleeding Disorders	☐	☐	________	Multiple Sclerosis	☐	☐	________
Cancer	☐	☐	________	Nails Disorders	☐	☐	________
Circulation Problems	☐	☐	________	Nerve Disorders	☐	☐	________
Diabetes	☐	☐	________	Obesity	☐	☐	________
Epilepsy	☐	☐	________	Phlebitis	☐	☐	________
Gout	☐	☐	________	Pulmonary Disease	☐	☐	________
Heart Disease	☐	☐	________	Rheumatic Fever	☐	☐	________
Hepatitis	☐	☐	________	Skin Problems	☐	☐	________
High Blood Pressure	☐	☐	________	Stomach/Intestine Prob	☐	☐	________
High Cholesterol	☐	☐	________	Stroke	☐	☐	________
HIV/AIDS	☐	☐	________	Thyroid Disorders	☐	☐	________
Injury Trauma – Major	☐	☐	________	Varicose Veins	☐	☐	________

10. Surgical History: Have you had surgery? ☐ Yes – if yes, please describe below ☐ No
Surgery / Date: ______________________________

11. Social History: ☐ Tobacco Use Packs per day ________ ☐ Alcohol Use ☐ Caffeine Use ☐ Drug Use (recreation, IV)
☐ Exercise Habits: ______________________________

12. Occupation: ______________________ Is your problem work related? ☐ Yes ☐ No

13. Are you currently pregnant? ☐ Yes ☐ No

14. Who is your family Doctor? ______________ Whom may we thank for referring you? ______________

Height: ______ Weight: ______ Shoe Size: ______ BP: ______ Pulse: ______ Resp: ______ Temp: ______

______________________	______________________	______________________
J. Christopher Moore, DPM	Lily L. Moore, DPM	Meredith Ward, DPM
Date: ______________	Date: ______________	Date: ______________

Moore Foot & Ankle Specialists, PA

REVIEW OF SYSTEMS

Patient Name: ______________________________ Date: ____________________

Please check any of the following that you are **currently experiencing** or **having recently experienced.**

Constitutional:			**Musculoskeletal:**		
Weight change	Y	N	Musculoskeletal Symptoms	Y	N
Fever	Y	N	Weakness of limbs	Y	N
Chills	Y	N	Prior Fracture	Y	N
			Joint Pain, Arthralgia	Y	N
Head, Eyes, Ears, nose, mouth & throat:			**Integumentary (Skin)**		
Dizziness	Y	N	Rash	Y	N
Problems with eyesight	Y	N	Sores	Y	N
Ringing in the ears	Y	N	Slow Healing	Y	N
Nosebleeds (Epistaxis)	Y	N	Infections	Y	N
Sore throat	Y	N			
			Neurological:		
			Balance problems	Y	N
Cardiovascular:			Numbness	Y	N
Chest pain / discomfort	Y	N	Convulsions	Y	N
Palpitations	Y	N			
Swelling lower extremity	Y	N	**Psychiatric:**		
Leg pain with exercise	Y	N	Anxiety	Y	N
			Depression	Y	N
Respiratory:			**Endocrine:**		
Difficulty Breathing	Y	N	Often thirsty	Y	N
Cough	Y	N			
Gastrointestinal:			**Hematologic / Lymphatic:**		
Decrease in appetite	Y	N	Bleeding problems	Y	N
Abdominal pain	Y	N	Anemia	Y	N
Nausea	Y	N			
Vomiting	Y	N			
Genitourinary:			**Allergic / Immunologic History:**		
Frequent urination	Y	N	RA	Y	N
Urinary symptoms	Y	N	Lupus	Y	N
Prior kidney disease	Y	N			
Often thirsty	Y	N			

Physician Signature: ______________________________ Date: ____________________

Moore Foot & Ankle Specialists, PA

Communication Permission Form

In order that we may serve you more efficiently, please fill out the following Information.

I ________________________ give permission for Moore Foot & Ankle Specialists, PA to share my health information with the following people who are involved in my care:

Please fill in the name and relationship and check the applicable box(s)

	Name	Phone Number	Relationship	Emergency Contact	Release of Medical Records	Resides With	Primary Caregiver
Primary Contact							
Legal Guardian							

____
Patient Name (Print)

____________________________ ___________________
Patient Signature Date