Patient Information

Date: _____

Patient Name: _____
Last Name First Name Middle Initial

Social Security Number _____ Date of Birth: _____

Address: _____
City State Zip Code

Home Phone (_____) _____ Work Phone (_____) _____

Cell Phone (_____) _____ Email: _____

Occupation: _____ Employer: _____

Married __Widowed __Single__ Minor __ If a minor, please list name of person responsible
_____

In case of an emergency:
Name: _____ Phone: (____) _____

Insurance Information:
Who is responsible for this account: _____

Name of Insurance: _____

Policy Number or Identification Number: _____

Group Number: _____

Subscriber/ Cardholder Name and DOB: _____

Name of Secondary Insurance: _____

Policy Number or Identification Number: _____

Group Number: _____

Subscriber/ Cardholder Name and DOB: _____

Phone: (754) 296-5900
Fax: (754) 296-5901
2951Northwest 49th Avenue Ste 204
Lauderdale Lakes, Fl 33313
www.SunshineFootandAnkle.com
Info@SunshineFootandAnkle.com

Pharmacy Information

Please provide details of your preferred pharmacy:

Pharmacy Name: _____

Pharmacy Address: _____

City: _____ **State:** _____ **ZIP Code:** _____

Pharmacy Phone Number: _____

Pharmacy Fax Number (if available): _____

Pharmacy Email (if available): _____

Insurance Assignment and Release

I certify that I have insurance coverage with the above listed insurance(s) and assign directly Sunshine Foot and Ankle, LLC all insurance benefits, if any, otherwise payable to me for services rendered. I authorize release to the indicated insurance company (ies) any medical information needed to determine these payments for relevant services.____Initial

I hereby agree to pay Sunshine Foot and Ankle, LLC in a timely fashion, for any and all services rendered which may or may not be covered by my insurance. This includes any co-payment, deductible and/or insurance payments that I may receive as a result of services rendered. Should my account not be paid in a timely manner I understand that I will be held responsible for any further collection and/or attorney fees. An additional fee of $25.00 will be imposed in the event of a returned check for insufficient funds.____Initial

Treatment Authorization: I hereby authorize treatment by Sunshine Foot and Ankle, LLC. I understand that this is a teaching clinic and that students may participate in my care. I consent that photographs or videotapes (lower extremities only) may be taken for educational purposes._____Initial

ALL CHARGES ARE DUE AT THE TIME OF SERVICE

I hereby authorize my physician _____ to obtain records from other sources as may be needed in the treatment of this patient. I hereby authorize the release if information concerning this patient's treatment to other physicians involved in the care and treatment of patient. I authorize the release of information to the insurance company as needed to pay for charges incurred by this patient.
I hereby authorize payment of insurance benefits otherwise due to me to be made directly to the above physician or hospital.
I understand that I am responsible for any amount not covered by the insurance company.

_____	_____	_____
Signature	Print Name (Patient, Beneficiary or Guardian)	Date

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Patient History

* Please fill out all forms to the best of your ability. The staff will go over the form and answer any questions you may have.

Name: _____ Date: ____/_____/_____

Age: _____ Height: _____ Weight: _____ Shoe Size: _____

1) What is the main problem with your feet or ankles? _____

_____

2) When did you first notice the condition?

_____

3) Is this an injury? ___Yes ___No
If yes, when did it occur? ____/_____/_____
If yes, did it happen at work? ___Yes ___ No
Are you claiming Workman's comp? __Yes ___No

4) Check all that apply:

Type of Pain: ___Burning ___Tingling ___Sharp ___Dull Ache
___Shooting ___Stabbing ___Numbness ___Throbbing

When is it Painful: ___Standing ___Walking ___After walking
___Worse when standing ___Activity ___Better as activity
___ During sports ___ Lying in bed ___ Always
___A.M. ___P.M. ___ With shoes ___ Without shoes

5) How painful is your condition? If 0- "no pain" and 10 – "the worst pain you have ever experienced", please circle your pain level:

0 1 2 3 4 5 6 7 8 9 10

6) How has this affected your daily routine and what activities does this keep you from performing?_____
_____

7) Have you had foot care before? ___Yes ___No By whom and when ?_____
_____

_____

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MEDICATIONS:

Pharmacy: _____ Phone: (____) _____-_____-_____

Medication	Dosage	How Often Taken?	What is it taken for?

ALLERGIES

☐ Please check if none

_____

Reactions: _____

MEDICAL HISTORY

* Please check any of the following conditions that you have or have had in the past.

☐ Diabetes	☐ Fibromyalgia	☐ Tumor	☐ Epilepsy	☐ Nerve Conditions
☐ Tuberculosis	☐ Arthritis	☐ Bursitis	☐ HIV	☐ Heart Conditions
☐ Rheumatic Fever	☐ Stroke	☐ Hepatitis	☐ Osteoporosis	☐ Mental Illness
☐ Gout	☐ Asthma/ COPD	☐ Glaucoma	☐ Hypertension	☐ Ulcers
☐ Anemia	☐ Thyroid Disease	☐ Hypotension	☐ Joint Implants	☐ Kidney Conditions
☐ Poor Circulation	☐ Colitis	☐ Colitis	☐ Cancer, type_____	☐ Others: _____

☐ Diabetes; what is the name, number, and address of the doctor treating your diabetes? _____

_____

Primary Care Physician Name: _____Phone: _____

When was your last visit with your PCP? ___/___/___ What is your average blood sugar? _____
Are you Pregnant? ___Yes ___No How many Months? _____
Are you up to date with your immunizations? ___Yes ___No

SURGICAL HISTORY

PROCEDURE	DATE	COMPLICATIONS

Have you ever been hospitalized other than for surgery? ___Yes ___No
Explain: _____
Have you ever had an injury to the lower extremity? ___Yes ___No
Explain: _____

FAMILY HISTORY

* Please check all that apply:

	FATHER	MOTHER	BROTHER	SISTER
Diabetes				
Heart Disease				
High Blood Pressure				
Arthritis				
Gout				
Thyroid issues				
Cancer (what type?)				
Other				

SOCIAL HISTORY

Date of last physical exam: ___/___/___ Occupation: _____

Do you exercise? ___Never ___Daily _____Weekly
Have you traveled out of the country in the last 6 months? ____Yes ____No

How many hours do you sleep at night: _____ Do you have pets? ____Yes ____No What kind? _____
Do you smoke? ___Yes ___No

Smoke: # packs per day? ___ # cigarettes per day? ___ # of years smoking? ____

If you do not smoke: Did you ever smoke? __ Yes ___No

Do you drink alcohol? ___Yes ___No
If Yes: How much? ___<1 per week ___1-2 per week ___1-2 per day ___more than 3 per day

Recreational drug use

Any type of drug use is a personal choice and will in no way adversely affect your relationship with the doctor. However, many drugs can interact with other medications and treatments with potential life threatening effects. Therefore, it is extremely important that you answer honestly. Your response will be held in the most strict patient-doctor confidentiality. Answer:_____Yes___No If Yes: What substance and how often used?

_____

REVIEW OF SYSTEMS

* If you are experiencing any of the following please circle

Head: chronic headaches, concussions, dizziness, loss of consciousness. **Eyes:** glasses, contacts, double vision, blurred vision, blindness, cataracts. **Ears:** decreased or loss of hearing, ringing in the ears, chronic earaches. **Nose:** drainage or infection, blockage, bleeding, sinusitis. **Throat:** chronic tonsillitis, laryngitis, difficulty swallowing, loss of speech. **Cardiovascular:** chest pain, shortness of breath, palpitations, murmurs, heart valve disease, anemia, leg cramps. **Respiratory:** bronchitis, pneumonia, difficulty breathing, wheezing, chronic cough. **Gastrointestinal:** nausea, vomiting, diarrhea, constipation, weight gain or loss, blood in stool, black stool, excessive gas, loss of appetite. **Genitourinary:** chronic kidney or bladder infections, problems voiding, pain with urination, dark or bloody urine, discharge from penis or vagina. **Gynecologic:** Irregular or painful periods, absence of period if not in menopause, vaginal discharge.

Do your legs swell? __Yes __No Do you have back problems or have had a back injury?__Yes__No

Other symptoms: _____

____ I am not experiencing any of the above symptoms.

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NOTICE OF PRIVACY PRCTICE (HIPAA REGULATIONS)

☐ You were provided with a document entitled "Notice of Privacy Practices." It is required by governmental regulations that all medical facilities provide you with this notice. Please check the box to acknowledge that you have read (or had the opportunity to read if you chose) and understand the notice. This is a copy of the notice that is yours to keep. If you do not want the copy, simply return it to the receptionist with your other materials.

CONSENT

I certify that the information above is true and correct to the best of my knowledge. I give permission to the doctor to administer and perform such procedures, including therapeutic and diagnostic injections, as may be deemed necessary I the diagnosis and/or treatment of my feet.

_____ _____

Signature of Patient (or Authorized Representative) Date

_____

Patient's Name (PRINT)

_____ _____

Name of Authorized Representative, if applicable (PRINT) Indicate Relationship to Patient

_____ _____

Interpreter's Signature Name of Interpreter (Print)

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