

PATIENT REGISTRATION – Please Print Clearly and Fill out Completely

PATIENT NAME Last First Middle			ACCOUNT #	SEX	MARITAL STATUS <input type="checkbox"/> S <input type="checkbox"/> M <input type="checkbox"/> D <input type="checkbox"/> W
RACE	ETHNICITY: HISPANIC NON HISPANIC	NATIONALITY		LANGUAGE	
DATE OF BIRTH	SOCIAL SECURITY NO.	HOME PHONE		CELL PHONE	
HOME ADDRESS APT NO			CITY	STATE	ZIP
REFERRED BY	FAMILY DOCTOR	FAMILY DOCTOR PHONE NUMBER		DATE OF ILLNESS/INJURY	
EMPLOYER	WORK PHONE	PERSONAL E-MAIL ADDRESS			
PARENT OR LEGAL GUARDIAN IF PATIENT IS A MINOR			RELATIONSHIP		
PREFERRED PHARMACY			PHARMACY PHONE		

RELEASE OF MEDICAL INFORMATION FOR BILLING PURPOSES

I hereby authorize Reconstructive Foot & Ankle Institute, LLC to release medical information to my insurance carrier(s) for the sole purpose of obtaining payment for my medical care. I agree that a copy of this release may be used in place of the original. I hereby authorize Reconstructive Foot & Ankle Institute, LLC to request records from my other treating physicians.

RELEASE OF MEDICAL INFORMATION FOR COORDINATION OF CARE

I hereby authorize Reconstructive Foot & Ankle Institute to release medical information to my referring physician, primary care doctor, case manager, pharmacy and any other individual involved in my medical care for sole purpose of facilitating my treatment. I understand that my medical information is confidential and that I have a choice to request that my physician not share my medical records with any of the above individuals. Should I choose to exercise this right I will provide in writing to my physician any of the individuals involved in my care to which I do not wish to receive my medical records. I agree that a copy of this release may be used in place of the original. I am aware that I may request that this release of Medical information may be revoked at any time by providing the physician's office with a dated and signed letter.

ACCURATE HISTORY

I understand that honest and complete answers to each question stated herein are important to the provision of my medical care and I have answered them to the best of my ability. I have been informed that if I am uncertain about any question on the form I should ask the doctor or member of the office staff for assistance.

ACKNOWLEDGMENT OF RECEIPT OF "NOTICE OF PRIVACY PRACTICES AND THE FINANCIAL POLICY"

The HIPPA educational pamphlet provides information about how Reconstructive Foot & Ankle Institute may use and disclose protected health information about you, and is compliant with the requirements of the Health Insurance Portability and Accountability Act of 1996(HIPPA). We reserve the right to change the terms described. Should this happen, you will receive a revised copy either by mail or in person. You have the right to request restrictions on how your protected health information may be used or disclosed for treatment, payment, or health care operations. We are not required to agree to your restrictions, but if we do, we are bound by our agreement with you. By signing below, you acknowledge receipt of our HIPPA regulations.

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read and understand the Notice and Financial Policy from Reconstructive Foot & Ankle Institute, LLC.

 Patient Name (printed)

 Patient or Legal Guardian Signature

 Date

CONTACTS

With consent Dr. Daniel Michaels, DPM, and/or his staff may discuss my protected health information, including course of treatment, scheduling and billing information, with the following individuals:

 Name and Relationship

 Name and Relationship

 Phone Number
 NO DESIGNEE

 Phone Number

Initial Comprehensive Foot & Ankle Questionnaire

Please complete this form before your first appointment at the Reconstructive Foot & Ankle Institute, LLC. Your careful answers will help us to understand your foot and ankle problem (s) and design the best treatment plan for you. You may feel concerned about what happens to the information you provide, as much of it is personal. Our records are strictly confidential. No outsider is permitted to see your case record without your written permission unless we are required to do so by law (e.g. Workmen's Compensation Claims).

Name: _____ Age: _____ Height: _____ Weight: _____

Shoe Size: _____ Family Physician: _____

How did you hear about our office? _____

Describe your foot or ankle problem: Right Left Bilateral (both) _____

Describe any treatment you have tried for your problem (including any treatment from previous doctors): _____

Where is your pain? (Check all that apply)

- Heel/Arch Pain
- Ankle pain (outside, inside, front, back of ankle)
- Foot pain (top, bottom)
- Toe Problem (big toe, 2nd, 3rd, 4th, 5th)

How long have you had your current problem?

_____ Days _____ Months
 _____ Weeks _____ Years

Onset of problem: How did your current problem start?

- Injury at work
- Injury, not at work
- Motor vehicle accident
- If there was a precipitating event not mentioned, what was it? _____
- Illness, non-injury
- Treatment caused (e.g. radiation, surgery, etc)
- Undetermined

How much pain do you have? What is the severity? Please circle one of the following:



No pain
0



Hurts a little
1-2-3



Hurts a little more
4-5



Hurts even more
6-7



Hurts a whole lot
8-9



Hurts worst
10

Timing of problem / pain: How often do you have your pain? (check one)

- Constantly (100% of the time)
- Occasionally (less than 30% of the time)
- Intermittently (30-60% of the time)
- Nearly constantly (60-95% of the time)

In general, during the past month, when has your pain/problem been the worst? (check one)

- Morning
- Night
- Afternoon
- Evening
- No typical pattern

Symptom quality: How would you describe your pain?

(Check all that apply and circle the dominant quality)

- Burning
- Sharp
- Cutting
- Throbbing
- Electric
- Cramping
- Dull/aching
- Pressure-like
- Shooting
- Pins and needles
- Walking on a pebble
- Pain on first step of day
- Other (describe) _____

Relieving and aggravating factors:

How does the following affect your pain? (check one for each activity)

Activity	Decrease	No Change	Increase
Standing			
Sitting			
Walking			
Exercise			
Elevation			

Check all that apply:

Aggravated by:
Weather ___ Shoe ___ Touch ___

Relieved by: Heat ___ Cold ___ Rest ___
Meds ___ Ace or compressive wrap ___

Activities and your pain:

How many blocks can you walk?

- Less than a block, or
- How many blocks? _____

To assist walking, I use a:

- Cane
- Walker
- Wheelchair
- No assistive device

Are you **NOT** able to perform any of the following activities of daily living? (Check all that apply)

- Going to work
- Performing household chores
- Wearing shoes
- Doing yard work or shopping
- Exercising
- Participating in recreational activities

Past personal & family medical history:

For each condition, check Yes or No for you, *and* check if you have a family history (FM HX)

	YES	NO	FM HX		YES	NO	FM HX
Alcoholism				Heart Condition			
Anemia				Heart Valve Issues			
Angina/ Chest Pain				High Blood Pressure			
Asthma				High Cholesterol			
Bleeding Disorder				Infection Prone			
Blood Clots (DVT)				Kidney Condition			
Blood Thinner				Liver Condition			
Bone Fracture				Obesity			
Cancer				Osteomyelitis			
Depression				Parkinson Disease			
Diabetes				Polio			
Emphysema				Raynauds			
Epilepsy / Seizures				Rheumatic Fever			
Fainting				Rheumatoid Arthritis			
Fibromyalgia				Sickle Cell			
Foot Disorder				Thyroid Condition			
Foot Surgery				Tuberculosis			
G.I. Condition				Ulcer			
Gout				Vascular Disease			
Heart Attack /Stroke				Vascular Necrosis			

Please list any other condition(s)

Have you ever been a smoker?

- Yes – Current
- Yes – In the past
- No – Never

If you smoke, how many packs per day?

_____ packs/day

For how many years did you smoke?

_____ years

If you are unemployed or employed part time, is this due to your present foot condition? Yes No

If you are currently unemployed, indicate how long you have been off work: _____

If you have diabetes please answer the following questions:

How long have you had diabetes? _____ Years _____ Months

What is your usual blood sugar level by finger stick? _____

How many times a day do you check your finger stick blood sugar? _____

Have you ever had a blood-clot? _____

Do you take insulin? _____

Past surgical history: Please list any hospitalizations/surgeries with approximate dates.

Surgeries/ Injuries	Date	Surgeries/ Injuries	Date
Abdominal surgery		CABG (heart bypass)	
Amputation		Cardiac Surgery	
Angioplasty		Cancer Surgery	
Ankle surgery		Cataract Surgery	
Appendectomy		Cholecystectomy	
Artificial joint		Cosmetic Surgery	
Back surgery		Foot Surgery	
Biopsy		GYN Surgery	
Bowel surgery		Vascular Surgery	

List other surgeries: _____

Allergies: What allergies do you have?

	Reaction		Reaction
Aspirin		Ampicillin	
Codeine		Tylenol	
Iodine (Seafood)		Eggs	
Novocain		NSAIDS	
Penicillin or other antibiotics		Latex	
Tape		Glove Powder	
Sulfa drugs		Demerol	
Cortisone		Morphine	

List any other allergies:

Current medications:

Name of Medication	Dose	Frequency

List any other medications:

Review of systems: Please circle yes or no if you have any of the following problems:

<input type="checkbox"/> Constitutional		
Good general health	Yes	No
Recent Weight changes	Yes	No
Night sweats, Fevers	Yes	No
Fatigue	Yes	No
<input type="checkbox"/> Eyes		
Wear glasses/ contacts	Yes	No
Blurred/ double vision	Yes	No
Eye disease or injury	Yes	No
Glaucoma	Yes	No
<input type="checkbox"/> Cardiovascular		
Chest pain	Yes	No
Palpitations	Yes	No
Heart Trouble	Yes	No
Swelling hands/feet	Yes	No
<input type="checkbox"/> Musculoskeletal		
Muscle pain or cramps	Yes	No
Stiffness/swelling joints	Yes	No
Joint pain	Yes	No
Trouble walking	Yes	No
<input type="checkbox"/> Integumentary (Skin/Breast)		
Change in hair or nails	Yes	No
Rashes or itching	Yes	No
Breast lump	Yes	No
Breast pain or discharge	Yes	No
<input type="checkbox"/> Endocrine		
Excessive thirst/urination	Yes	No
Thyroid disease	Yes	No
Hormone problem	Yes	No
<input type="checkbox"/> Genitourinary – Male Only		
Blood in Urine	Yes	No
Kidney stones	Yes	No
Kidney Failure	Yes	No
Dialysis	Yes	No
<input type="checkbox"/> Psychiatric		
Insomnia	Yes	No
Confusion/ Memory loss	Yes	No
Depression	Yes	No

<input type="checkbox"/> Ears/Nose/Throat/Mouth		
Hearing loss or ringing	Yes	No
Sinus Problems	Yes	No
Nose Bleeds	Yes	No
Sore throat/ voice change	Yes	No
<input type="checkbox"/> Gastrointestinal		
Nausea/ vomiting	Yes	No
Abdominal pain	Yes	No
Rectal bleeding	Yes	No
Bowel problems	Yes	No
<input type="checkbox"/> Respiratory		
Shortness of breath	Yes	No
Cough	Yes	No
Wheezing/ asthma	Yes	No
Coughing up blood	Yes	No
<input type="checkbox"/> Neurological		
Frequent headaches	Yes	No
Paralysis or tremors	Yes	No
Convulsions/ seizures	Yes	No
Numbness/ tingling	Yes	No
<input type="checkbox"/> Allergic/ Immunologic		
Food allergies	Yes	No
Aspirin allergies	Yes	No
Antibiotic allergies	Yes	No
<input type="checkbox"/> Hematologic/ Lymphatic		
Bruise easily	Yes	No
Slow to heal	Yes	No
Enlarged glands	Yes	No
<input type="checkbox"/> Genitourinary – Female Only		
Blood in Urine	Yes	No
Kidney stones	Yes	No
Kidney Failure	Yes	No
Dialysis	Yes	No
<input type="checkbox"/> Other		

