Lagman Foot and Ankle

Today's Date: ______________

Patient Information

Last Name ______________________________

First Name ______________________________

Soc Security # ___________________________

Date of Birth ____________________________

Gender Male / Female

Marital Status S M D W

Address _______________________________

City _________________________________

State ____________ Zip _______________

Email _________________________________

Home Phone ____________________________

Work Phone ____________________________

Cell Phone _____________________________
(Please circle preferred phone number)

Physician Information

Primary Doctor __________________________

Phone # _______________________________

Date last seen __________________________

Patient Employment

Employed / Retired / Student / Disabled / None

Employer _______________________________

Phone Number ___________________________

Insurance Information

Primary Ins ______________________________

ID# ______________________________

Secondary Ins ____________________________

ID# ______________________________

Primary Insurance Cardholder Information
(if different than patient)

Full Name _______________________________

Date of Birth ____________________________

Address _________________________________

____

Soc Security # ___________________________

Responsible Party
(Person to receive statements – if different than patient)

Full Name _______________________________

Date of Birth ____________________________

Address _________________________________

____

Soc Security # ___________________________

Employer ________________________________

Phone Number _____________________________

Would you like to receive email reminders for your appointments? (must be supplied on this form)

Yes No

Email __________________________________

Medical History

Chief Complaint (Please describe your foot problem – What brought you in today?)

History of Present Illness

How long has this foot problem been bothering you? ________________________________

What treatment, if any, has been performed? ________________________________

____

Hospitalizations / Surgeries (please list year if known)

Drug Allergies (List drug, type of reaction, and severity – very mild, mild, moderate, severe)

Past Medical History (Please check any conditions you currently have or have ever had)

Cardiovascular

___ Congestive Heart Failure
___ Deep Vein Thrombosis (DVT)
___ High Blood Pressure
___ Stroke
___ Other cardiovascular problems

Please list:

Respiratory

___ Asthma
___ COPD
___ Emphysema
___ Lung Cancer
___ Pneumonia
___ Tuberculosis
___ Other respiratory problems

Please list:

Dermatological

___Cellulitis
___STD
___Psoriasis
___ Warts
___ Other skin conditions

Please list:

Endocrine

___ Diabetes ___ Insulin? Blood sugar _________ Last checked ________
___ Other

Please list:

GI / GU

___ Stomach Ulcers ___ GERD ___Crohn's
___ Liver conditions ___ Stomach / Bowel ___ Kidney disease
___ Other GI /GU

Please list:

Hematological

___ Anemia ___ Bleeding abnormalities
___ Leukemia ___ Lymphoma
___ Other hemotological

Please list:

Neurological

___ Alzheimer's ___ Migraines ___ Neuropathy
___ Neurofibromatosis ___ Seizure Disorder ___ Sciatica
___ Other neuro

Please list:

Psychiatric

___ Alcoholism ___ Drug Abuse
___ Depression ___ Dementia
___ Other psychiatric

Please list:

Musculoskeletal

___ Amputation ___ Gout ___ Fibromyalgia
___Arthritis ___ Bone Infection ___ Osteoporosis
___ Other muscular

Please list:

Family History: Maternal (mother) / Paternal (father)

M___ P___ Alcoholism	M___ P___ Bleeding Disorders	M___ P___ Respiratory
M___ P___ Anesthesia Problems	M___ P___ Diabetes	M___ P___ Seizures
M___ P___ Arthritis	M___ P___ Heart Problems	M___ P___ Stroke
M___ P___ Cancer	M___ P___ Neuro Problems	

Social History

Use Tobacco? Y / N How much?____________ How long? ___________

Drink Alcohol? Y / N How much? ____________ How long? ___________

Illicit Drug use? Y / N Please list _____________________ How often? _____________

What type of work do you do? ____

Name of Pharmacy ____________________________ Phone Number ___________________

Shoe Size ______________ Height ______________ Weight ____________________

Review of Systems: (Please circle any symptoms you currently have or recently have had)

General			
Change in weight	Change in health	Change in strength	
Head			
Headaches	Dizziness	Head trauma	
Eyes			
Change in vision	Pain in eyes	Excessive tearing	
Ears			
Change in hearing	Ringing in ears	Bleeding from ears	
Nose			
Nose bleeds	Head cold / drainage	Obstruction in nose	
Mouth			
Dental difficulties	Gingival bleeding		
Neck			
Stiffness	Pain / tenderness	Noted masses	
Breast			
Noted lumps	Tenderness	Swelling	Nipple discharge
Chest			
Difficulty breathing	Wheezing	Bloody sputum	coughing
Heart			
Chest pains	Heart palpitations	Fainting	
Abdomen			
Change in appetite	Difficulty swallowing	Abdominal pains	
Change in bowel habit	Vomiting		
Urinary			
Urinary urgency	Painful urination		
Musculoskeletal			
Pain in muscle / joints	Limited range of motion	Abnormal sensations	Numbness
Neurological			
Weakness	Tremors	Seizures	
Changes in mentation	Loss of coordination		
Psychiatric			
Depressive symptoms	Changes in sleep habits	Changes in though content	

**** List of Medications** (please list drug, dosage, and frequency if know – may attach sheet if needed)
If you have a current list of medications, please let us make a copy for your convenience

Authorization for Treatment / Authorization to Release Information / Financial Policy

(Please read carefully and sign at the bottom. Please ask any questions if necessary)

The information provided is correct to the best of my knowledge and I consent to such diagnostic procedures and medical care as deemed necessary by the doctor for my treatment. I understand that no guarantees have been given or implied as to the success of my treatment. I agree to fully cooperate with Lagman Foot and Ankle doctors and staff concerning my treatment and that failure to do so may jeopardize the outcome of my treatment. I also consent to have photographs taken which will be used solely for medical education. X-rays that are taken in this office are the property of Lagman Foot and Ankle. Copies of the x-rays can be obtained at the expense of the patient.

I hereby authorize the release of any information necessary to file a claim with my insurance company and assign benefits to Lagman Foot and Ankle. I understand that I am responsible for any charges incurred during any visit or treatment by the doctors and staff of Lagman Foot and Ankle. My insurance company may not cover my charges for the following reasons: I did not bring a referral for this care, the referral did not arrive in time for the visit, my insurance company may not cover the service, my insurance may not be in effect, the charges may be applied to my deductible/co pay. Lagman Foot and Ankle will file with my insurance when appropriate, but I will be ultimately responsible for all charges. A fee schedule can be obtained up on request.

I understand that payment is due at the time of service for co-pays, deductibles, and with no insurance or for non-covered services and due immediately upon receipt of statement after filed with my insurance company. I understand that a late fee of $30 may be applied to my bill if not paid within 30 day period. Unpaid bills may result in Responsible Party being sent to a collections agency. If this occurs, a $30 service fee will be added to the account. All NSF checks will result in a $20 service fee plus payment of the original balance by cash, credit card, cashier's check, or postal money order.

______________________________ ____________________

Patient/Parent/Guardian **Date**

Acknowledgement of Receipt of Notice of Privacy Practices

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read if I so chose) and understand the Notice.

______________________________ ______________________________

Patient Name (Please Print) Parent or Authorized Representative (if applicable)

______________________________ ______________________________

Signature Date

How did you hear about us?

Please indicate how you heard about our office. Check all that apply.

_____ REAL YELLOW PAGES

_____ SUNSHINE PAGES

_____ PELICAN PAGES

_____ NEWSPAPER AD

_____ INSURANCE BOOK

_____ INSURANCE WEBSITE

_____ GOOGLE / SEARCH ENGINE

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_____ PHYSICIAN

____
NAME OF PHYSICIAN

____
CITY

____
TELEPHONE #

_____ FRIEND OR FAMILY

____
PLEASE SPECIFY NAME

_____ OTHER

____
PLEASE SPECIFY