



Welcome to our office! We appreciate you choosing us!

Today's date: _____ Patient name: _____

Who are you seeing today? Dr. Dellinger Dr. Kiessling Dr. Britton
 Dr. Pierce Dr. Buk Dr. Herring

SSN#: _____ Date of birth: _____ **M / F**

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

Home phone: () _____ Cell phone: () _____ Work: () _____

Email Address: _____ Place of employment: _____

Emergency Contact: _____ Phone#: () _____

Primary insurance: _____ Policy/ID#: _____

Secondary insurance: _____ Policy/ID#: _____

Tertiary insurance: _____ Policy/ID#: _____

Primary policy holder if other than the patient: _____ their date of birth: _____

** If patient is a minor, who is the parent or legal guardian? _____*

Preferred pharmacy: _____ Phone#: () _____

Primary Care Physician: _____

Date you were last seen by your Primary Care Physician: _____

Who may we thank for referring you to our practice? _____

Marital Status: *(please circle one)* Single Married Divorced Widowed Other

Primary language spoken: ENGLISH *Other:* _____

Race: _____ Ethnicity: _____

How may we contact you (check all that apply)? :

Phone Email Mail SMS (Text Message)

With whom may we leave a message with if a concern about your care should arise?

Patient only Patient and/or spouse other family member _____

Foot & Ankle Associates of Central Arkansas

Why are you here today ?: _____

How severe is your pain? (very mild) 0 1 2 3 4 5 6 7 8 9 10 (severe)

How long have you had this problem? _____

Anything else you want to tell us about your problem: _____

Tell us about your medical history:

Do you have any drug allergies? **Y** or **N** *If yes, please list:* _____

Are you under a pain management contract ? Y N

If so, who is your pain management physician ? _____

Please check the appropriate box if you are currently being treated for these:

High blood pressure	Y	N	Gout	Y	N	epilepsy or seizures	Y	N
Stroke/heart attack	<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Circulation problem	<input type="checkbox"/>	<input type="checkbox"/>
Heart problems	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid disease	<input type="checkbox"/>	<input type="checkbox"/>
Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	Liver/hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	Shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Kidney/dialysis	<input type="checkbox"/>	<input type="checkbox"/>	HIV/AIDS	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Stomach/GI	<input type="checkbox"/>	<input type="checkbox"/>	High cholesterol	<input type="checkbox"/>	<input type="checkbox"/>
Parkinson's	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Alzheimer's/dementia	<input type="checkbox"/>	<input type="checkbox"/>

Any other not on the list: _____

Please list any major surgeries you have had in the past 10 years:

If you've had surgery before, did you have any type of reaction to any medication or anesthesia or any type of complication related to the surgery? **Y or N**

** If yes, what ?* _____

Height: ? _____ Weight: ? _____ What is your shoe size ? _____

Do you have any family history of medical diseases or problems ? If yes, please fill in:

On your mother's side: _____

On your father's side: _____

Do you drink alcohol? **Y or N** *If yes, how often / much?* _____

Do you smoke? **Y or N** *If yes, how much?* _____

Please answer yes or no:

Constitutional:	Y <input type="checkbox"/>	N <input type="checkbox"/>	fever	Y <input type="checkbox"/>	N <input type="checkbox"/>	chills	Y <input type="checkbox"/>	N <input type="checkbox"/>	dizziness
Cardiovascular:	<input type="checkbox"/>	<input type="checkbox"/>	chest pain	<input type="checkbox"/>	<input type="checkbox"/>	murmur	<input type="checkbox"/>	<input type="checkbox"/>	shortness of breath
	<input type="checkbox"/>	<input type="checkbox"/>	stroke	<input type="checkbox"/>	<input type="checkbox"/>	heart attack	<input type="checkbox"/>	<input type="checkbox"/>	other_____
Endocrine:	<input type="checkbox"/>	<input type="checkbox"/>	diabetes	<input type="checkbox"/>	<input type="checkbox"/>	weight loss	<input type="checkbox"/>	<input type="checkbox"/>	excessive thirst
	<input type="checkbox"/>	<input type="checkbox"/>	frequent urination				<input type="checkbox"/>	<input type="checkbox"/>	other_____
Gastrointestinal:	<input type="checkbox"/>	<input type="checkbox"/>	diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	bloody stool	<input type="checkbox"/>	<input type="checkbox"/>	stomach ulcers
	<input type="checkbox"/>	<input type="checkbox"/>	nausea / vomiting	<input type="checkbox"/>	<input type="checkbox"/>	other_____			
Skin:	<input type="checkbox"/>	<input type="checkbox"/>	eczema	<input type="checkbox"/>	<input type="checkbox"/>	psoriasis	<input type="checkbox"/>	<input type="checkbox"/>	rash
	<input type="checkbox"/>	<input type="checkbox"/>	open sores or wounds				<input type="checkbox"/>	<input type="checkbox"/>	other_____
Musculoskeletal:	<input type="checkbox"/>	<input type="checkbox"/>	joint pain	<input type="checkbox"/>	<input type="checkbox"/>	bone problems	<input type="checkbox"/>	<input type="checkbox"/>	arthritis
	<input type="checkbox"/>	<input type="checkbox"/>	muscle problems	<input type="checkbox"/>	<input type="checkbox"/>	weakness	<input type="checkbox"/>	<input type="checkbox"/>	other_____
Neurological:	<input type="checkbox"/>	<input type="checkbox"/>	numbness	<input type="checkbox"/>	<input type="checkbox"/>	tingling / numbness			
	<input type="checkbox"/>	<input type="checkbox"/>	seizures	<input type="checkbox"/>	<input type="checkbox"/>	fibromyalgia			
	<input type="checkbox"/>	<input type="checkbox"/>	other_____						

Please list **all** medications you take, prescription and over the counter:

If you have a list already, you may provide it to a staff member so we may photocopy it instead:

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Check here if you take **NO** medications.

Permission to treat

I understand and agree (regardless of my insurance status), that I am ultimately responsible for my bill and the professional services provided to me. I understand I am responsible for the balance of my account after adjudication by any insurance I may have. I have read all the information and answered all the questions. I certify this information is true and correct to the best of my knowledge. I also authorize Foot & Ankle Associates to deposit any monies received in my name by my insurance company.

Authorization for Release of Medical Record Information

I understand that sometimes the information contained in my medical record is needed by other parties. These may include attorneys, my insurance company, or other physicians that may be treating me. By signing this form, I authorize Foot & Ankle Associates of Central Arkansas, to submit any information requested by any of the above named entities. I also authorize Foot & Ankle Associates of Central Arkansas to obtain my medication list and/or history, electronically, through their electronic health record, if needed through the course of treatment. I understand that I may revoke this consent at any time, except where information has already been released, by sending a written request to the Office Manager or treating doctor, and the appropriate form signed. The revoked consent will take effect on the date of the signature.

Acknowledgement of Receipt of Notice of Privacy Practices

Copies of the privacy policy are located on the front counter.

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

Financial Policy

Copies of the Financial Policy are located on the front counter.

I acknowledge that I was offered a copy of the Financial Policy and that I have read (or had the opportunity to read if so chosen) and understand the Notice.

By signature, I understand that I have read and agree with the above statements.

Printed name: _____

Date: _____

If patient is a minor, the legal guardian: _____

Signed name: _____