New Patient Information sheet

Bay Area Foot & Ankle Specialists - Dr. Chad Clause

Patient Name: _____Date: ____/____/_____

☐ Female ☐ Male

Provide E-mail if you would like confirmations:_____

Address: _____ Apt#: _____

City: _____ State: _____Zip: _____Phone #: _____

Cell #: _____ Wk #:_____ Social Soc. #: _____-____-_____

Date of Birth: _____/_____/_____ Age: _____ ☐Single ☐Married ☐Widowed ☐Divorced

Emergency Contact: _____ Phone#: _____

Referred by: _____

Primary Care Physician: _____
(Medicare patients must fill out)

Address: _____Phone #: _____

Approximate date last seen by PCP: _____

Insurance Information

(Please present your insurance card(s) and picture ID to receptionist)

Primary Insurance Co. Name: _____

Please fill out policy holder information if *not* the patient:

Name: _____ D/O/B: _____

SS #: _____-____-_____ Relationship to the patient: _____

Secondary Insurance Co. Name: _____

***Release of Authorization/ Assignment of Benefits**

I authorize the release of any medical information necessary to process my insurance claims. I authorized and request payment of my medical benefits directly to my physician. I agree that this authorization will cover all medical services until such authorization is revoked by me in writing.

***Acknowledgement 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 understood the notice.

_____ _____

Signature of Patient/ Guardian **Date**

NAME:_____ DATE: _____

WHAT BRINGS YOU IN TO THE OFFICE TODAY?_____

_____

HOW WOULD YOU DESCRIBE YOUR PAIN (IF ANY) SHARP THROBBING SHOOTING
ACHING PINS/NEEDLES BURNING

LOCATION OF PAIN OR COMPLAINT ANKLE ACHILLES HEEL
FORFOOT ARCH MIDFOOT
SOLE BALL TOP
TOES NAILS

HOW LONG HAS YOUR PROBLEM BEEN PRESENT?_____
ONSET OF PAIN GRADUAL? OVER TIME
SUDDEN AS RESULT OF INJURY?

IS YOUR PAIN/CONDITION AGGRAVATED BY : WEIGHT BEARING STANDING RUNNING
STOOPING WALKING SHOES

WHAT HAVE YOU DONE TO HELP RELIEVE YOUR PROBLEM?
REST ICE ELEVATION CHANGE SHOE MEDICATION
STRETCHING TRIMMING TOENAIL WHIRPOOL ANTIBIOTIC CREAM

DO YOU HAVE ANY OF THE FOLLOWING? CHECK NEXT TO OR CIRCLE -

HIGH BLOOD PRESSURE	HEPATITIS	INSULIN DEPENDENT DIABETES
HIV AIDS	HEART ATTACK MI	NON INSULIN DIABETES
STROKE CVA	ANEURYSM	BLOOD CLOT
VALVE PROLASPE	ANGIOPLASTY	OPEN HEART/BYPASS SURGERY
PACEMAKER	CONGESTIVE HEART FALIURE	CIRCULATION PROBLEMS
FATIGUE	ASTHMA	BLOCKED ARTERIES
NAUSEA	BRONCHITIS	PHLEBITIS
CHILLS	LUNG CANCER	LIVER DISORDER
IMPAIRED VISION	EMPHYSEMA	RENAL FAILURE
CATARACTS	COLLAPSED LUNG	SICKLE CELL
GLAUCOMA	SHORTNESS OF BREATH	CANCER
HEARING LOSS	PNEUMONIA	BLOOD TRANSFUSION
DIZZINESS	TUBERCULOSIS	LOSS OF BALANCE
NUMBNESS	SWELLING	VERICOSE VEINS
GOUT	EPILEPSY	MENTAL ILLNESS

MEDICATIONS: _____

_____

PAST SURGERIES / HOSPITALIZATIONS _____

_____

ALLERGIES? _____ _____ NO KNOWN DRUG ALLERGIES

DO YOU TAKE BLOOD THINNERS? COUMADIN HEPARIN ASPIRIN PLAVIX

DO YOU SMOKE? _____ HOW MUCH?_____

SHOE SIZE _____

DO YOU DRINK? _____HOW MUCH?_____

PHARMACY _____PHONE_____

BAY AREA FOOT & ANKLE FOOT SPEACIALIST - DR. CHAD CLAUSE