

ORTHOPAEDIC SURGERY

PRACTICE LIMITED
TO THE
FOOT AND ANKLE
CHILDREN & ADULTS



A Medical Group, Inc

RONALD SMITH, M.D.

Dear Patient,

We are pleased that you have selected our office for your orthopaedic foot and ankle care.

Please fill out the enclosed forms completely, marking the “NONE” boxes where appropriate and listing where indicated the approximate dates of previous foot and ankle services, treatments, and evaluations.

The forms are detailed but allow us to have information that helps to provide comprehensive medical or surgical care for your foot and ankle.

Please bring with you all X-RAYS, CT AND BONE SCAN STUDIES, AND MRI FILMS AND REPORTS that you have had done in regard to your foot or ankle problem.

Thank you for your assistance. We look forward to meeting you.

Sincerely,

Ronald W. Smith, M.D.

BOFAC ORTHOPAEDIC FOOT AND ANKLE HISTORY

Last _____ First _____ M.I. ____ Age ____ Todays Date _____

I have brought in x-rays or other images today: Yes No
 Source of x-rays/images (office or hospital name) _____

Occupation _____ Duration _____

REFERRING PARTY: (Please give name)

Physician _____ Phone _____ Fax _____
 Address _____ E-Mail _____
 City _____ State _____ ZIP _____
 Friend _____ Family Member _____
 Insurance Company _____ Attorney _____
 Other _____

PERSONAL PHYSICIAN (Same as referring physician)

Name _____ Phone _____ Fax _____
 Address _____ E-Mail _____
 City _____ State _____ ZIP _____
 Date of last visit _____

PRESENT GOAL IN SEEKING EVALUATION: Check one or more.

Relief of pain Correction of deformity Improvement of appearance
 Second opinion Other _____

MAIN PROBLEM: Check one or more.

Pain or aching Swelling Weakness Stiffness Deformity Lump
 Instability or giving out Other _____

LOCATION & DURATION OF MAIN PROBLEM: Check one or more. (indicate # of weeks, months, years)

Problem:	Duration Of Symptoms			Or Date Of Onset		
Leg	R <input type="checkbox"/>	L <input type="checkbox"/>	# __ weeks	# __ months	# __ years	_____
Ankle	R <input type="checkbox"/>	L <input type="checkbox"/>	# __ weeks	# __ months	# __ years	_____
Heel	R <input type="checkbox"/>	L <input type="checkbox"/>	# __ weeks	# __ months	# __ years	_____
Bunion	R <input type="checkbox"/>	L <input type="checkbox"/>	# __ weeks	# __ months	# __ years	_____
Top of arch	R <input type="checkbox"/>	L <input type="checkbox"/>	# __ weeks	# __ months	# __ years	_____
Sole of arch	R <input type="checkbox"/>	L <input type="checkbox"/>	# __ weeks	# __ months	# __ years	_____
Side of the foot	R <input type="checkbox"/>	L <input type="checkbox"/>	# __ weeks	# __ months	# __ years	_____
Ball of foot	R <input type="checkbox"/>	L <input type="checkbox"/>	# __ weeks	# __ months	# __ years	_____
Great toe	R <input type="checkbox"/>	L <input type="checkbox"/>	# __ weeks	# __ months	# __ years	_____
2nd toe	R <input type="checkbox"/>	L <input type="checkbox"/>	# __ weeks	# __ months	# __ years	_____
3rd toe	R <input type="checkbox"/>	L <input type="checkbox"/>	# __ weeks	# __ months	# __ years	_____
4th toe	R <input type="checkbox"/>	L <input type="checkbox"/>	# __ weeks	# __ months	# __ years	_____
5th toe	R <input type="checkbox"/>	L <input type="checkbox"/>	# __ weeks	# __ months	# __ years	_____

* If multiple problems, indicate the most severe in the right column.

DESCRIPTION OF ONSET: Check one or more.

Congenital-- Crush- Repetitive use-- Sudden onset --- Work-related ----
 Fall ----- Twist-- Direct blow ----- Gradual onset --- Sports-related ---
 No Injury ---- Other _____

BRIEFLY DRAW LOCATION OF MAIN PROBLEMS ON THE DIAGRAM ON THE NEXT PAGE.

Patient's Name _____

Chart No. _____

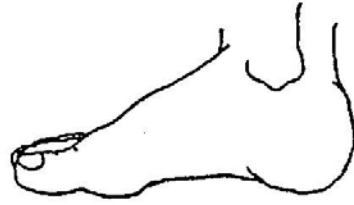
Date _____

CIRCLE AREA OF SYMPTOMS (label pain, swelling, weakness, stiffness, numbness, lumps, etc.)

RIGHT



Lateral
(Outside)

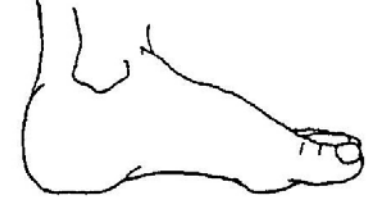


Medial
(Inside)

LEFT



Lateral
(Outside)



Medial
(Inside)



Dorsal
(Top)

RIGHT



Plantar
(Bottom)

LEFT



Dorsal
(Top)



Plantar
(Bottom)

BOFAC ORTHOPAEDIC FOOT AND ANKLE HISTORY

Briefly describe what happened when symptoms started, **and specify your location** at onset (home, work, etc.)

PREVIOUS TREATMENT OR EVALUATIONS: NONE (If none, skip to SELF CARE)

The **FIRST** doctor/E.R./Urgent Care I saw for this problem:

Name _____ City _____

This doctor is a: Emergency Room Doctor Podiatrist Company doctor

Family doctor Orthopedic surgeon Other _____

Date of first exam _____ **Date of last visit** _____ **# of visits** _____

Tests: X-Rays Blood Tests Nerve Tests CT scan Bone Scan MRI

TREATMENT:

Steroid injections -----	<input type="checkbox"/>	How many _____	Date of last one _____	Helped? Yes <input type="checkbox"/>	No <input type="checkbox"/>
Anti-inflammatory pills --	<input type="checkbox"/>	Drug names _____		Helped? Yes <input type="checkbox"/>	No <input type="checkbox"/>
Pain pills -----	<input type="checkbox"/>	Drug names _____		Helped? Yes <input type="checkbox"/>	No <input type="checkbox"/>
Physical therapy -----	<input type="checkbox"/>	Number of visits _____		Helped? Yes <input type="checkbox"/>	No <input type="checkbox"/>
Pads/shoe modification	<input type="checkbox"/>	Type _____		Helped? Yes <input type="checkbox"/>	No <input type="checkbox"/>
Orthotics -----	<input type="checkbox"/>	Type _____		Helped? Yes <input type="checkbox"/>	No <input type="checkbox"/>
Cast <input type="checkbox"/> or Walker Boot	<input type="checkbox"/>	How long? _____		Helped? Yes <input type="checkbox"/>	No <input type="checkbox"/>
Surgery performed -----	<input type="checkbox"/>	Recommended surgery, did not do <input type="checkbox"/>		Helped? Yes <input type="checkbox"/>	No <input type="checkbox"/>
Other _____				Helped? Yes <input type="checkbox"/>	No <input type="checkbox"/>

The **SECOND** doctor I saw for this problem:

Name _____ City _____

This doctor is a: Emergency Room Doctor Podiatrist Company doctor

Family doctor Orthopedic surgeon Other _____

Date of first exam _____ **Date of last visit** _____ **# of visits** _____

Tests: X-Rays Blood Tests Nerve Tests CT scan Bone Scan MRI

TREATMENT:

Steroid injections -----	<input type="checkbox"/>	How many _____	Date of last one _____	Helped? Yes <input type="checkbox"/>	No <input type="checkbox"/>
Anti-inflammatory pills --	<input type="checkbox"/>	Drug names _____		Helped? Yes <input type="checkbox"/>	No <input type="checkbox"/>
Pain pills -----	<input type="checkbox"/>	Drug names _____		Helped? Yes <input type="checkbox"/>	No <input type="checkbox"/>
Physical therapy -----	<input type="checkbox"/>	Number of visits _____		Helped? Yes <input type="checkbox"/>	No <input type="checkbox"/>
Pads/shoe modification	<input type="checkbox"/>	Type _____		Helped? Yes <input type="checkbox"/>	No <input type="checkbox"/>
Orthotics -----	<input type="checkbox"/>	Type _____		Helped? Yes <input type="checkbox"/>	No <input type="checkbox"/>
Cast <input type="checkbox"/> or Walker Boot	<input type="checkbox"/>	How long? _____		Helped? Yes <input type="checkbox"/>	No <input type="checkbox"/>
Surgery performed -----	<input type="checkbox"/>	Recommended surgery, did not do <input type="checkbox"/>		Helped? Yes <input type="checkbox"/>	No <input type="checkbox"/>
Other _____				Helped? Yes <input type="checkbox"/>	No <input type="checkbox"/>

IF YOU SAW MORE THAN TWO DOCTORS FOR THIS PROBLEM PLEASE CHECK AND CONTINUE ON THE BACK SIDE OF THIS PAGE.

BOFAC ORTHOPAEDIC FOOT AND ANKLE HISTORY

The **THIRD** doctor I saw for this problem:

Name _____ City _____
 This doctor is a: Emergency Room Doctor Podiatrist Company doctor
 Family doctor Orthopedic surgeon Other _____

Date of first exam _____ **Date of last visit** _____ **# of visits** _____

Tests: X-Rays Blood Tests Nerve Tests CT scan Bone Scan MRI

TREATMENT:

Steroid injections -----	<input type="checkbox"/>	How many _____	Date of last one _____	Helped?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Anti-inflammatory pills --	<input type="checkbox"/>	Drug names _____		Helped?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Pain pills -----	<input type="checkbox"/>	Drug names _____		Helped?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Physical therapy -----	<input type="checkbox"/>	Number of visits _____		Helped?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Pads/shoe modification	<input type="checkbox"/>	Type _____		Helped?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Orthotics -----	<input type="checkbox"/>	Type _____		Helped?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Cast <input type="checkbox"/> or Walker Boot	<input type="checkbox"/>	How long? _____		Helped?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Surgery performed -----	<input type="checkbox"/>	Recommended surgery, did not do <input type="checkbox"/>		Helped?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Other _____				Helped?	Yes <input type="checkbox"/>	No <input type="checkbox"/>

The **FOURTH** doctor I saw for this problem:

Name _____ City _____
 This doctor is a: Emergency Room Doctor Podiatrist Company doctor
 Family doctor Orthopedic surgeon Other _____

Date of first exam _____ **Date of last visit** _____ **# of visits** _____

Tests: X-Rays Blood Tests Nerve Tests CT scan Bone Scan MRI

TREATMENT:

Steroid injections -----	<input type="checkbox"/>	How many _____	Date of last one _____	Helped?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Anti-inflammatory pills --	<input type="checkbox"/>	Drug names _____		Helped?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Pain pills -----	<input type="checkbox"/>	Drug names _____		Helped?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Physical therapy -----	<input type="checkbox"/>	Number of visits _____		Helped?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Pads/shoe modification	<input type="checkbox"/>	Type _____		Helped?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Orthotics -----	<input type="checkbox"/>	Type _____		Helped?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Cast <input type="checkbox"/> or Walker Boot	<input type="checkbox"/>	How long? _____		Helped?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Surgery performed -----	<input type="checkbox"/>	Recommended surgery, did not do <input type="checkbox"/>		Helped?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Other _____				Helped?	Yes <input type="checkbox"/>	No <input type="checkbox"/>

The **FIFTH** doctor I saw for this problem:

Name _____ City _____
 This doctor is a: Emergency Room Doctor Podiatrist Company doctor
 Family doctor Orthopedic surgeon Other _____

Date of first exam _____ **Date of last visit** _____ **# of visits** _____

Tests: X-Rays Blood Tests Nerve Tests CT scan Bone Scan MRI

TREATMENT:

Steroid injections -----	<input type="checkbox"/>	How many _____	Date of last one _____	Helped?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Anti-inflammatory pills --	<input type="checkbox"/>	Drug names _____		Helped?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Pain pills -----	<input type="checkbox"/>	Drug names _____		Helped?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Physical therapy -----	<input type="checkbox"/>	Number of visits _____		Helped?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Pads/shoe modification	<input type="checkbox"/>	Type _____		Helped?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Orthotics -----	<input type="checkbox"/>	Type _____		Helped?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Cast <input type="checkbox"/> or Walker Boot	<input type="checkbox"/>	How long? _____		Helped?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Surgery performed -----	<input type="checkbox"/>	Recommended surgery, did not do <input type="checkbox"/>		Helped?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Other _____				Helped?	Yes <input type="checkbox"/>	No <input type="checkbox"/>

BOFAC ORTHOPAEDIC FOOT AND ANKLE HISTORY

FOOT AND ANKLE SURGERY: list earliest surgery first NONE

- 1. Date _____ Doctor _____ Hospital _____
Type of surgery _____ Right _____ Left _____
Helped? Yes No Complications? (list) _____
Other _____
2. Date _____ Doctor _____ Hospital _____
Type of surgery _____ Right _____ Left _____
Helped? Yes No Complications? (list) _____
Other _____
3. Date _____ Doctor _____ Hospital _____
Type of surgery _____ Right _____ Left _____
Helped? Yes No Complications? (list) _____
Other _____

SELF CARE: None Other _____
Changed shoes Trimmed calluses Store bought pads or arch supports

ANTICIPATED SURGERY:
Would consider surgery if the doctor thinks it's necessary? Yes No

FACTORS OF PAIN OR DISCOMFORT: check one or more.
Walking in shoes ----- Being on my feet all day -----
Walking barefooted ----- Cold, damp weather -----
First getting up in the morning ----- Walking while carrying loads -----
Walking after resting or sitting ----- Climbing stairs or ladders -----
At rest or at night ----- Squatting -----
Other _____

FACTORS OF RELIEF: check one or more.
Staying off my feet ----- Removing shoes -----
Elevating feet ----- Hanging feet over side of bed -----
Applying ice ----- Special shoes (type _____)
Rubbing my feet ----- Other _____

FREQUENCY OF PAIN: check one or more. None
Some pain is always present -----
Frequency of pain depends on activities -----

FREQUENCY OF SWELLING: check one or more. None
Some swelling is always present -----
Frequency of swelling depends on activities -----

FREQUENCY OF INSTABILITY: check one or more. None

(For patients with ankle problems: Instability means that the ankle feels as though it will give out, actually gives out, or "resprains.")
Walking on uneven surfaces Playing sports Type of sports? _____
Instability occurs several times a week a month a year
Instability is becoming more frequent less frequent

BOFAC ORTHOPAEDIC FOOT AND ANKLE HISTORY

AIDS FOR WALKING: (used frequently) check one or more. None
 Wheelchair Crutches Cane Other _____

ACTIVITY LIMITATIONS

Regular Activities **Prior** To Pain /Injury (Check one or more)

	Current Limitations	
	Do with difficulty (now)	Unable to do (now)
Bicycling ----- <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bowling ----- <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Golfing ----- <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Running ----- <input type="checkbox"/> miles/week ___ years running ___	<input type="checkbox"/>	<input type="checkbox"/>
Walking ----- <input type="checkbox"/> miles/week ___ years walking ___	<input type="checkbox"/>	<input type="checkbox"/>
Other sports -----	<input type="checkbox"/>	<input type="checkbox"/>
House/yard work ----- <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Usual occupation ----- <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other -----	<input type="checkbox"/>	<input type="checkbox"/>

After walking ___ blocks or ___ minutes, I have to stop walking because of my symptoms.

Generally, over time, I'm: Better Same Worse

Sports (if applicable): Current Sport _____ Position _____
 Level (highschool, club, etc.) _____ Team _____ Coach _____

OTHER BODY AREAS AFFECTED BY MY FOOT/ANKLE INJURY/PROBLEM: None
How Related

Head ----- _____
 Neck ----- _____
 Low Back ----- _____
 Shoulders ----- R L _____
 Hips ----- R L _____
 Knees ----- R L _____

PREVIOUS INJURIES RELATED TO THIS PROBLEM: (same foot or ankle) NONE
 Date of previous injury ___/___ Describe _____
 When present problem began was this previous problem completely resolved? Yes No

BOFAC ORTHOPAEDIC FOOT AND ANKLE HISTORY
(General History)

GENERAL MEDICAL HISTORY

MEDICAL ILLNESSES/CONDITIONS:

NONE

Check as many as are applicable

- Gout-----
- Psoriasis -----
- Heart disease (type)_____
- High blood pressure -----
- Bad circulation in feet -----
- Bad leg veins (Varicose, Phlebitis, DVT)-----
- Bleeding disorder/tendency-----
- Anemia-----
- Ankle swelling -----
- Lung disease (type, include embolus, asthma, etc.) -----
- Stomach/intestinal (type)_____
- Kidney disease (type)_____

- Bladder problems (type)_____
- Seizures -----
- Stroke -----
- Liver disease (hepatitis, etc.) -----
- Glaucoma -----
- Neurological (type)_____
- Psychiatric illness (type)_____
- Cancer (type)_____
- Thyroid disease (type)_____
- Hyperthermia (with anesthesia) -----
- Previous MRSA infection -----

- Arthritis, Degenerative -----
- Arthritis, Rheumatoid (Blood Test Postive) -----
- Arthritis, Other (Lupus, etc.) (type)_____
- Diabetes -----
- Other _____

Age at onset ___ Years
 Age at onset ___ Years
 Age at onset ___ Years Insulin Yes No

WOMEN ONLY:

- Not pregnant Possibly pregnant Definitely pregnant
- Pre Menopausal Post Menopausal

CURRENT MEDICATIONS: NONE

Name of medication (Include Insulin)	Dose	Frequency	Duration of use	
			Months _____	Years _____
_____	_____	_____	Months _____	Years _____
_____	_____	_____	Months _____	Years _____
_____	_____	_____	Months _____	Years _____
_____	_____	_____	Months _____	Years _____
_____	_____	_____	Months _____	Years _____
_____	_____	_____	Months _____	Years _____
_____	_____	_____	Months _____	Years _____

ASPIRIN (Anacin, Empirin)? Yes more than 10 tablets/month Yes less than 10 tablets/month No

PAST STEROIDS: I have taken steroid pills in the past. Yes No

HAVE YOU RECEIVED A HEPATITIS B VACCINATION? Yes No Unsure

LAST TETANUS IMMUNIZATION? Within past 5 years More than 5 years ago

ALLERGIES: NONE

(include medicine, adhesive tape, iodine products, xray dyes, foods, etc.)

Medication, etc.	----- Reactions -----			
_____	Rash <input type="checkbox"/>	Anaphylaxis <input type="checkbox"/>	Nausea <input type="checkbox"/>	Other _____
_____	Rash <input type="checkbox"/>	Anaphylaxis <input type="checkbox"/>	Nausea <input type="checkbox"/>	Other _____
_____	Rash <input type="checkbox"/>	Anaphylaxis <input type="checkbox"/>	Nausea <input type="checkbox"/>	Other _____
_____	Rash <input type="checkbox"/>	Anaphylaxis <input type="checkbox"/>	Nausea <input type="checkbox"/>	Other _____
_____	Rash <input type="checkbox"/>	Anaphylaxis <input type="checkbox"/>	Nausea <input type="checkbox"/>	Other _____

Non Medications _____

BOFAC ORTHOPAEDIC FOOT AND ANKLE HISTORY

(General History)

OTHER ORTHOPAEDIC PROBLEMS: None

Back
Neck

Shoulder
Hip

R L
R L

Arm R L
Knee R L

Hand R L
Leg R L

Describe other

orthopaedic problems _____

OPERATIONS: (other than foot and ankle) NONE

1. Date ___/___/___ Type _____
Complications (Including anesthetic)? _____
2. Date ___/___/___ Type _____
Complications (Including anesthetic)? _____
3. Date ___/___/___ Type _____
Complications (Including anesthetic)? _____
4. Date ___/___/___ Type _____
Complications (Including anesthetic)? _____

OTHER HOSPITALIZATIONS: (other than for surgery or childbirth) NONE

1. Date ___/___/___ Diagnosis _____
2. Date ___/___/___ Diagnosis _____
3. Date ___/___/___ Diagnosis _____

TOBACCO/ALCOHOL/RECREATIONAL DRUG USE/HIV RISK FACTORS:

- I have never smoked. I am a smoker. (___ packs per day) # Years Smoking _____
- I have been a smoker and I stopped smoking in (year) _____
- I do not use alcohol.
- I drink alcohol occasionally.
- I drink 3 or more alcoholic beverages per day, several times a week.

FAMILY HISTORY: Do/did any "blood relatives" have any of the following? None to list

Disease	Relationship	Comment
Cancer-----	<input type="checkbox"/> _____	_____
Heart disease-----	<input type="checkbox"/> _____	_____
Diabetes -----	<input type="checkbox"/> _____	_____
Arthritis -----	<input type="checkbox"/> _____	_____
Bone disease -----	<input type="checkbox"/> _____	_____
Foot or ankle problem -----	<input type="checkbox"/> _____	_____
Hyperthermia (with anesthesia)-----	<input type="checkbox"/> _____	_____
Other-----	<input type="checkbox"/> _____	_____

(General History)

BOFAC ORTHOPAEDIC FOOT AND ANKLE HISTORY

SOCIAL HISTORY:

Home members

- Live alone
- Live with family members (relationship(s)) _____
- Other _____

Height _____ Weight _____ Shoe Size _____ Width _____

Right handed Left handed

PLEASE USE THIS SPACE FOR ADDITIONAL PERTINENT INFORMATION OR SPECIFIC QUESTIONS YOU WISH TO ASK.

Signature of patient, guardian or witness

BOFAC ORTHOPAEDIC FOOT AND ANKLE HISTORY

(Work Injury History)

IF INJURED AT WORK, please give the following information:

Name of company _____

City _____

Length of time with company at time of injury _____

Your usual job title _____

Job description (Patient's usual job / activities) _____

How many hours do/did you stand and/or walk in 8-hour day? _____

Carry loads? Never Occasionally (1/3) Frequently (2/3)

Usual weight of load: (range) _____

Climb? Never Occasionally (1/3) Frequently (2/3)

Use foot controls? Never Occasionally (1/3) Frequently (2/3)

How long have/had you been doing this type of work? _____

What was your job activity at time of injury? _____

Your specific location at time of injury? _____

Was your supervisor notified of the injury? Yes No

Relationship with supervisor at time of injury: Good Fair Poor

Level of job satisfaction: High Average Low

PREVIOUS WORK INJURIES: None

	<u>Date Injured</u>	<u>Diagnosis (note right or left if applicable)</u>	<u>Time off Work</u>
1.	___/___	_____	_____
2.	___/___	_____	_____
3.	___/___	_____	_____
4.	___/___	_____	_____

BOFAC ORTHOPAEDIC FOOT AND ANKLE HISTORY
(Work Injury History)

CURRENT WORK STATUS:

1. Are you now working? Yes No

(If "no," skip to question #5)

2. Are you doing the same type of work as before? Yes No

3. If you are doing different work, please explain: _____

4. Did you miss time from work due to the injury? Yes No

(If "no," skip to question #6)

5. If you missed work, please indicate the periods of missed work.

From (date) _____ to _____

From (date) _____ to _____

From (date) _____ to _____

6. If you have you been on work restrictions, please indicate the periods. None

From (date) _____ to _____. Type of restriction _____

From (date) _____ to _____. Type of restriction _____

From (date) _____ to _____. Type of restriction _____

7. If you are NOT working now, when did you last work? Date _____ Not applicable

• If you are NOT working now, is it because of this injury? Yes No Not applicable

If "No," list reason for not working. _____

• Is your old job still available Yes No Not applicable

Do you have an attorney involved with this problem? Yes No

Name of Attorney: _____ Phone _____

Address: _____ City _____ State _____ ZIP _____

Date of attorney acquisition _____

Reason for attorney acquisition _____

PATIENT INFORMATION RECORD (PLEASE PRINT OR WRITE LEGIBLY)

PATIENT				EMAIL:			
PATIENT NUMBER		DOCTOR			TODAY'S DATE		
PATIENT'S LEGAL NAME			DATE OF BIRTH	AGE	SOCIAL SECURITY #		CELL NO.
NAME PREFERENCE			DRIVER'S LICENSE #		SEX		MARITAL STATUS
STREET ADDRESS <input type="checkbox"/> PERMANENT <input type="checkbox"/> TEMPORARY			CITY AND STATE		ZIP CODE	AREA CODE	HOME PHONE NO.
PATIENT'S EMPLOYER			OCCUPATION (INDICATE IF STUDENT)		AREA CODE		BUSINESS PHONE NO.
EMPLOYER'S STREET ADDRESS			CITY AND STATE			ZIP CODE	
IN CASE OF EMERGENCY CONTACT:				PHONE #		RELATIONSHIP	
SPOUSE'S NAME		DATE OF BIRTH		SOCIAL SECURITY NO.		DRIVER'S LICENSE #	
SPOUSE'S EMPLOYER			OCCUPATION (INDICATE IF STUDENT)			BUSINESS PHONE NO.	
EMPLOYER'S STREET ADDRESS			CITY AND STATE			ZIP CODE	
WHO REFERRED YOU TO THIS OFFICE?							
HAVE WE EVER TREATED ANY MEMBERS OF YOUR FAMILY? (Y / N)				NAME OF YOUR FAMILY DOCTOR:			

IF THE PATIENT IS A MINOR OR STUDENT							
MOTHER'S NAME		STREET ADDRESS / CITY / STATE / ZIP				HOME PHONE #	
MOTHER'S EMPLOYER		BUSINESS PHONE NO.		SOCIAL SECURITY NO.			
EMPLOYER'S STREET ADDRESS		CITY / STATE /				ZIP	
FATHER'S NAME		STREET ADDRESS / CITY / STATE / ZIP				HOME PHONE #	
FATHER'S EMPLOYER		BUSINESS PHONE #		SOCIAL SECURITY NO.			
EMPLOYER'S STREET ADDRESS		CITY / STATE / ZIP					

INSURANCE INFORMATION							
PERSON RESPONSIBLE FOR PAYMENT, IF NOT ABOVE		STREET ADDRESS			CITY / STATE / ZIP		HOME PHONE #
INSURANCE NAME & ADDRESS		NAME OF POLICY HOLDER		CERTIFICATE #		GROUP #	
INSURANCE NAME & ADDRESS		NAME OF POLICY HOLDER		CERTIFICATE #		GROUP #	
MEDICARE			MEDICARE #				
MEDICAID		PROGRAM #			COUNTY #		

INJURY							
DESCRIBE INJURY AND HOW IT HAPPENED							
<input type="checkbox"/> HOME <input type="checkbox"/> WORK <input type="checkbox"/> AUTO <input type="checkbox"/> OTHER (Explain)							
					DATE OF INJURY		APPROXIMATE TIME OF INJURY

PROVIDER'S FINANCIAL POLICY

Please note that payment in full is required at the time of service. For your convenience, we accept personal checks, Visa, Master Charge or American Express, as well as cash. Any insurance coverage that you may have is intended to protect you against financial loss and not as payment in full for your care. Payment in full for your care is your responsibility and may not be postponed until the time your insurance reimburses you. This agreement will remain in effect until revoked by (the patient) (or provider?) in writing. A photocopy of this document is to be considered as valid as the original.

PATIENT'S INSURANCE AUTHORIZATION

I hereby authorize the processing of the listed medical insurance, either electronically or manually, by the listed facility. My signature authorizes payment of all major medical and/or surgical benefits to which I am entitled from the listed insurer to be paid to the listed provider assignee. I further authorize assignee to release all medical and/or insurance claim information necessary to secure the payment(s). I recognize my financial obligation for any co-insurance or deductible and non-covered services that may be required. This agreement will remain in effect until revoked by me in writing. A photocopy of this document is to be considered as valid as the original.

PATIENT'S TREATMENT AUTHORIZATION

I authorize treatment by the Balance Orthopaedic Foot and Ankle Center. I have read the above paragraph regarding payment of fees, and I understand that I am solely responsible for all the charges incurred, regardless of insurance coverage or liability of another party. I will make sure that my claims are paid promptly.

Patient's Name (Please Print) Signature of Patient/Guardian Date

TREATMENT OF MINOR

I authorize Balance Orthopaedic Foot and Ankle Center to treat the minor named below.

Minor's Name Signature of Parent/Guardian Date