FOOT AND ANKLE
ASSOCIATES OF LANCASTER

Today's Date: _____

NEW PATIENT PAPERWORK

NAME: _____ **DOB:** _____

SEX (circle): M / F **ETHNICITY/RACE (circle all that apply):** Declined to Specify | Hispanic/Latino White | Asian | Black/African American | Native American/Native Alaskan Native Hawaiian/ Pacific Islander

SSN (last 4 only): XXX-XX-_____ **MARITAL STATUS:** Single | Married | Widowed | Divorced

ADDRESS: _____

CITY: _____ **STATE:** _____ **ZIP:** _____

HOME PHONE: _____ **CELL PHONE:** _____

▢ Home Phone ▢ Cell Phone (Please indicate preferred contact method)

****

EMAIL: _____

▢ ***YES, please give me access to the patient portal for office notes, online payments, etc.***

****

Appointment Reminder Preference: ▢ Email ▢ Text

By selecting the checkboxes above, the patient agrees to receive text and/or email notifications from the practice.

Written Contact Preference (circle):

▢ Email | ▢ Postal Mail

EMERGENCY CONTACT NAME: _____ **PHONE:** _____

RELATIONSHIP TO PATIENT (circle): Spouse | Child | Friend | Caregiver | Other

Who may we speak to or leave a message with in regards to your medical information?

▢ Spouse Name: _____ Phone: _____

▢ ChildName: _____ Phone: _____

▢ Friend Name: _____ Phone: _____

▢ Caregiver Name: _____ Phone: _____

▢ Other Name: _____ Phone: _____

▢ None

INSURANCE / PAYMENT DETAILS

PRIMARY INSURANCE: _____

ARE YOU THE INSURED? YES | NO (if no complete the info below for the insured member)

SUBSCRIBER NAME:_____ **SEX:** M / F **DOB:** _____

▢ **Check if address and phone is same as patient** **PHONE:** _____

ADDRESS: _____ **RELATIONSHIP TO INSURED:**
Spouse | Child | Self | Other

CITY: _____ **STATE:** _____ **ZIP:** _____

****

SECONDARY INSURANCE: _____

ARE YOU THE INSURED? YES | NO (if no complete the info below for the insured member)

SUBSCRIBER NAME:_____ **SEX:** M / F **DOB:** _____

▢ **Check if address and phone is same as patient** **PHONE:** _____

ADDRESS: _____ **RELATIONSHIP TO INSURED:**
Spouse | Child | Self | Other

CITY: _____ **STATE:** _____ **ZIP:** _____

****

▢ Check here if someone else is responsible for patient payments (guarantor)

GUARANTOR NAME: _____ **PHONE:** _____

GUARANTOR ADDRESS: _____

CITY: _____ **STATE:** _____ **ZIP:** _____

MEDICAL / FAMILY HISTORY

Please check (✔️) if you or a family member has the following medical conditions:

CONDITION	SELF	MOTHER	FATHER
Anxiety	▫ Yes	▫ Yes	▫ Yes
Arthritis	▫ Yes	▫ Yes	▫ Yes
Asthma	▫ Yes	▫ Yes	▫ Yes
Blood Clot	▫ Yes	▫ Yes	▫ Yes
Blood Disorder	▫ Yes	▫ Yes	▫ Yes
Breathing Disorder	▫ Yes	▫ Yes	▫ Yes
Cancer	▫ Yes	▫ Yes	▫ Yes
Cholesterol (High)	▫ Yes	▫ Yes	▫ Yes
Circulation Issues	▫ Yes	▫ Yes	▫ Yes
Depression	▫ Yes	▫ Yes	▫ Yes
Diabetes	▫ Yes	▫ Yes	▫ Yes
Disorder of function of Stomach	▫ Yes	▫ Yes	▫ Yes
Epilepsy	▫ Yes	▫ Yes	▫ Yes
Gastrointestinal Disorder	▫ Yes	▫ Yes	▫ Yes
Gout	▫ Yes	▫ Yes	▫ Yes
HIV	▫ Yes	▫ Yes	▫ Yes
Heart Attack	▫ Yes	▫ Yes	▫ Yes
Heart Disease	▫ Yes	▫ Yes	▫ Yes
Heart Murmur	▫ Yes	▫ Yes	▫ Yes
Hypertension (High Blood Pressure)	▫ Yes	▫ Yes	▫ Yes
Kidney Disease	▫ Yes	▫ Yes	▫ Yes
Liver Disorder	▫ Yes	▫ Yes	▫ Yes
Mental Illness	▫ Yes	▫ Yes	▫ Yes
Migraine	▫ Yes	▫ Yes	▫ Yes
Musculoskeletal Pain	▫ Yes	▫ Yes	▫ Yes
Neuropathy	▫ Yes	▫ Yes	▫ Yes
Skin Disorder	▫ Yes	▫ Yes	▫ Yes
Sleep Apnea	▫ Yes	▫ Yes	▫ Yes

Stroke	▫ Yes	▫ Yes	▫ Yes
Thyroid Disease	▫ Yes	▫ Yes	▫ Yes
Other:	▫ Yes	▫ Yes	▫ Yes

CURRENT REVIEW OF BODY SYSTEMS

Please check (✔️) the following conditions that apply to your health.
Check here if none apply -> ☐

1. CONSTITUTIONAL
- ☐ Chills
- ☐ Fatigue
- ☐ Fever
- ☐ Weight gain
- ☐ Weight loss

2. HEENT
- ☐ Hearing loss
- ☐ Sinus pressure
- ☐ Vision changes

3. RESPIRATORY
- ☐ Cough
- ☐ Shortness of breath
- ☐ Wheezing

4. CARDIOVASCULAR
- ☐ Chest pain
- ☐ Pain while walking (Claudication)
- ☐ Edema
- ☐ Heart palpitations

5. GASTROINTESTINAL
- ☐ Abdominal pain
- ☐ Blood in stool
- ☐ Constipation
- ☐ Diarrhea
- ☐ Heartburn
- ☐ Loss of appetite
- ☐ Nausea
- ☐ Vomiting

6. GENITOURINARY
- ☐ Painful urination (Dysuria)
- ☐ Excessive amount of urine (Polyuria)
- ☐ Urinary frequency

7. METABOLIC/ENDOCRINE
- ☐ Cold intolerance
- ☐ Heat intolerance
- ☐ Excessive thirst (Polydipsia)
- ☐ Excessive hunger (Polyphagia)

8. NEUROLOGICAL
- ☐ Dizziness
- ☐ Extremity numbness
- ☐ Extremity weakness
- ☐ Headaches
- ☐ Seizures
- ☐ Tremors

9. PSYCHIATRIC
- ☐ Anxiety
- ☐ Depression

10. INTEGUMENTARY
- ☐ Breast discharge
- ☐ Breast lump
- ☐ Hives
- ☐ Mole change(s)
- ☐ Rash
- ☐ Skin lesion

11. MUSCULOSKELETAL
- ☐ Back pain
- ☐ Joint pain
- ☐ Joint swelling
- ☐ Neck pain

12. HEMATOLOGIC
- ☐ Easily bleeds
- ☐ Easily bruises
- ☐ Lymphedema
- ☐ Issues with blood clots

13. PODIATRY:

▫ Foot pain ▫ Heel paint ▫ Joint pain
▫ Bunion ▫ Hammertoe ▫ Club foot
▫ Warts ▫ Callous ▫ Ulcer
▫ Shin splints ▫ Neuropathy ▫ Gout
▫ Low arches ▫ High arches ▫ Flat feet
▫ Ingrown nail ▫ Plantar Fasciitis
▫ Nail fungus ▫ Athlete's Foot

MEDICAL INFORMATION

ALLERGIES (please list names of allergies):

_____ _____ _____

_____ _____ _____

MEDICATIONS (please list name of medication and dosage below OR attach med list):

_____ _____ _____

_____ _____ _____

SOCIAL HISTORY:

Have you ever used tobacco products? (circle one)

Current Heavy Smoker | Current Light Smoker | Former Smoker | Never Smoked

What type of tobacco do/did you use?

Cigarettes | Cigars | Pipe | Chewing Tobacco | Dipping Tobacco

SURGICAL HISTORY (please all surgical procedures here):

_____

_____

VITALS: Height: _____ Weight: _____ Shoe Size: _____

PRIMARY CARE DOCTOR: _____ **DATE LAST SEEN:**_____

PRACTICE NAME: _____ **PHONE:** _____

****

Please check (✔️) the boxes to agree and sign below:

▫ **The information on my intake form is correct to the best of my knowledge. I understand that throughout my treatment I am responsible for notifying the physician and/or medical staff of any and all updates to the information listed above.**

▫ **I authorize the providers and staff at Foot and Ankle Associates to retrieve my medication history and perform medical treatments on me.**

▫ **I authorize payment of medical benefits to the Foot and Ankle Associates of Lancaster. I agree that I am responsible for any payments not covered by my insurance and/or any outstanding co-insurance amounts.**

▫ **I authorize the release of any medical information necessary to process any claims associated with my treatment**

▢ **I hereby give my express consent to Foot & Ankle Associates or any business associate with Foot & Ankle Associates to contact me on a telephone number provided, regardless of whether the telephone number is associated with a cell phone or any other telephone. These contacts may be necessary to enforce any part of this agreement to collect any outstanding balance on the account created under this agreement.**

_____ _____

Signature Date