**PATIENT INFORMATION:**

**DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ PATIENT NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SSN: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**ADDRESS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**CITY: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ STATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ZIP: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**HOME PHONE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ CELL PHONE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**WORK PHONE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**PATIENT EMAIL: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**MARITAL STATUS: S M W D LANGUAGE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**RACE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ETHNICITY: NON-HISPANIC HISPANIC OTHER**

**PATIENT EMPLOYER: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ EMPLOYER PHONE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**OCCUPATION: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**EMERGENCY CONTACT NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ PHONE NUMBER: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**MAY WE LEAVE A MESSAGE WITH THIS EMERGENCY CONTACT? YES NO**

**IF NO, IS THERE ANYONE ELSE WE HAVE PERMISSIO TO SPEAK WITH ABOUT YOUR HEALTHCARE? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**INSURANCE INFORMATION:**

|  |  |  |
| --- | --- | --- |
| **PRIMARY INSURANCE** |  | **SECONDARY INSURANCE** |
| **POLICY HOLDER NAME** |  | **POLICY HOLDER NAME** |
| **RELATIONSHIP TO PATIENT** |  | **RELATIONSHIP TO PATIENT** |
| **POLICY #** |  | **POLICY #** |
| **GROUP #** |  | **GROUP #** |
| **POLICY HOLDER SSN POLICY HOLDER DOB** |  | **POLICY HOLDER SSN POLICY HOLDER DOB** |
| **EMPLOYER** |  | **EMPLOYER** |

**HOW DID YOU HEAR ABOUT OUR PRACTICE? RADI0 INTERNET SOCIAL MEDIA**

 **OTHER \_\_\_\_\_\_\_\_\_\_\_**

**MEDICAL INFORMATION**

**WHAT PROBLEM YOU ARE HERE FOR TODAY? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**RIGHT OR LEFT IS THIS DUE TO AN ACCIDENT/INJURY? NO YES**

 **IS THIS WORKER’S COMPENSATION? \_\_\_\_\_\_\_\_\_ DATE PAIN/INJURY STARTED: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**PRIMARY CARE PHYSICIAN: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**REFERRING PHYSICIAN: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**SOCIAL HISTORY**

**SMOKING: NEVER FORMER CURRENT EVERY DAY SMOKER**

**CIRCLE ONE: CIGARETTES CIGARS PIPE CHEWING TOBACCO OTHER\_\_\_\_\_\_\_\_\_\_\_**

**PACKS PER DAY: \_\_\_\_\_\_\_\_\_\_\_\_\_ HOW LONG: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**RECREATIONAL DRUG USE: YES NO WHAT KIND: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ AMOUNT: \_\_\_\_\_\_\_\_\_**

**DO YOU DRINK ALCOHOL? YES NO CIRCLE ONE: BEER WINE LIQUOR AMOUNT: \_\_\_\_\_\_\_\_\_\_**

**PAST MEDICAL HISTORY**

|  |  |  |
| --- | --- | --- |
|  Y N |  |  Y N |
| ASTHMA \_\_\_ \_\_\_ |   | DIABETES \_\_\_\_ \_\_\_\_ |
| KIDNEY DISEASE \_\_\_ \_\_\_ |   |  TYPE I TYPE II  |
| LUPUS \_\_\_ \_\_\_ |   | GOITER \_\_\_\_ \_\_\_\_ |
| BLEEDING TENDENCY \_\_\_ \_\_\_ |   | LUNG DISEASE \_\_\_\_ \_\_\_\_ |
| HEART DISEASE \_\_\_ \_\_\_ |   | TUBERCULOSIS \_\_\_\_ \_\_\_\_ |
| EPILEPSY \_\_\_ \_\_\_ |   | HIV/AIDS \_\_\_\_ \_\_\_\_ |
| HIGH BLOOD PRESSURE \_\_\_ \_\_\_ |   | OSTEOARTHRITIS /ARTHRITIS \_\_\_\_ \_\_\_\_ |
| POLIO \_\_\_ \_\_\_  |   | ALCOHOLISM \_\_\_\_ \_\_\_\_ |
| HEPATITIS (A B C) \_\_\_ \_\_\_ |   | SICKLE CELL ANEMIA \_\_\_\_ \_\_\_\_ |
| RA \_\_\_ \_\_\_ |   | COLITIS \_\_\_\_ \_\_\_\_ |
| ANEMIA \_\_\_ \_\_\_ |   | STROKE \_\_\_\_ \_\_\_\_ |
| MIGRAINES \_\_\_ \_\_\_ |   | STOMACH ULCERS \_\_\_\_ \_\_\_\_ |
| CANCER \_\_\_ \_\_\_ |   | DEPRESSION/ANXIETY \_\_\_\_ \_\_\_\_ |
|  TYPE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |   | COPD \_\_\_\_ \_\_\_\_ |
|   |   | OTHER  |

**PAST SURGICAL HISTORY**

**PLEASE LIST ALL SURGERIES AND DATE**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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**FAMILY HISTORY**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| FAMILY HX | MOTHER | FATHER | SISTER | BROTHER | DAUGHTER | SON |
| ALCOHOL ABUSE |   |   |   |   |   |   |
| BREAST CANCER |   |   |   |   |   |   |
| CORONARY ARTERY DISEASE |   |   |   |   |   |   |
| CLOTTING DISORDER |   |   |   |   |   |   |
| COLON CANCER |   |   |   |   |   |   |
| COPD |   |   |   |   |   |   |
| DIABETES |   |   |   |   |   |   |
| DRUG ABUSE |   |   |   |   |   |   |
| HYPERLIPIDEMIA |   |   |   |   |   |   |
| HYPERTENSION |   |   |   |   |   |   |
| KIDNEY DISEASE |   |   |   |   |   |   |
| MENTAL ILLNESS |   |   |   |   |   |   |
| OSTEOPOROSIS |   |   |   |   |   |   |
| STROKE |   |   |   |   |   |   |
| THYROID DISEASE |   |   |   |   |   |   |
| CANCER |   |   |   |   |   |   |
|  |  |  |

**PLEASE LIST ALL ALLERGIES**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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**MEDICATIONS**

|  |  |  |  |
| --- | --- | --- | --- |
| **MEDICATION** | **DOSAGE** | **HOW OFTEN** | **WHY DO YOU TAKE THIS** |
|   |   |   |   |
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**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ I DO NOT HAVE ANY ALLERGIES**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ I DO NOT TAKE ANY MEDICATIONS**

**PHARMACY: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**SIGNATURE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**CONSENT FOR MEDICAL TREATMENT**

**\_\_\_\_** I authorize Dr. Khumalo and personnel of Khumalo Foot And Ankle Clinic, Inc, to render medical treatment and evaluations needed. I further authorize order of x-rays, injections, casting or other diagnostic tests and treatment as necessary.

**CONSENT AND RELEASE OF MEDICAL INFORMATION**

**\_\_\_\_** I understand that I have rights regarding my protected health information. These rights are governed by the Health Insurance Portability Act of 1996, (HIPPA). I have been informed and given the opportunity to review and receive a copy of the Khumalo Foot and Ankle Clinic, Inc, Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information.

I hereby authorize the release and disclosures of my protected health information for treatment or payment for health care operations. I understand that any and all records concerning my personal and medical history are the confidential property of Khumalo Foot And Ankle Clinic, Inc.

I agree that Khumalo Foot And Ankle Clinic, Inc, may request and use my prescription medication history from other healthcare providers or third party pharmacy benefit payors for treatment purposes.

I agree that by providing my email address I am giving consent for Khumalo Foot And Ankle Clinic, Inc, to set me up for a patient portal account. I also agree that by providing my cell phone number I am giving consent for Khumalo Foot And Ankle Clinic, Inc, to contact me by this phone number.

**CONSENT FOR FINANCIAL RESPONSIBILITY**

**\_\_\_\_** My insurance policy is a contract between myself and my insurance carrier. I am ultimately responsible for payment in full for all medical services provided to me. I acknowledge full financial responsibility for services rendered by Khumalo Foot And Ankle Clinic, Inc. I understand that payment of charges incurred is due at the time of service unless other definite financial arrangements are made prior to treatment. I agree to pay all collection and attorney fees, if applicable. In the event of default of payment of charges. I assign benefits to and authorize direct payment Khumalo Foot And Ankle Clinic, Inc, of which it is entitled. This also includes proceeds and benefits accruing under any settlement, structure or otherwise, or awarded in judgement for personal injuries caused by a third party for payment of services rendered by Khumalo Foot And Ankle Clinic, Inc. I agree to pay for all charges not paid pursuant to this agreement. I agree in order for Khumalo Foot And Ankle Clinic, Inc, and/or any of its Business Associates may contact me at any telephone number associated with my account, including cellular numbers, which could result in charges to me. I may also be contacted by text message or email, using only email addresses I provide.

**Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICE**

I acknowledge that I have been offered and/or received a copy of Khumalo Foot And Ankle, Inc Privacy Practice.

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Patient or Legal Guardian Relationship Date

**CONSENT TO USE PROTECTED HEALTH INFORMATION (PHI) AS DESCRIBED BELOW**

I consent to Khumalo Foot And Ankle Clinic, Inc, disclosing my identifiable health information to my insurance company and/or other purposes of treatment, payment and healthcare operations, as described in the Notice of Privacy Practices that I have been offered and/or received. Furthermore, I authorize Khumalo Foot And Ankle Clinic, Inc, to disclose my identifiable health information for other purposes listed in the Notice of Privacy Practices to the extent permitted by applicable law.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient or Legal Guardian Relationship Date