ARCHER FOOT & ANKLE CLINIC **WELCOME TO OUR OFFICE**

PLEASE PRINT & CHECK THE FOLLOWING PATIENT INFORMATION FOR OUR RECORDS.

PATIENT'S NAME_____

BIRTH DATE_____SOC.SEC#_____

ADDRESS_____CITY_____STATE_____ZIP_____

AREA CODE&PHONE#-HOME_____WORK_____

AREA CODE & FAX# HOME_____WORK_____

AREA CODE & CELL# HOME_____WORK_____

EMAIL HOME_____WORK_____

MARTIAL STATUS: SINGLE_____; MARRIED_____; WIDOWED_____; DIVORCED_____; SEPARATED _____

OCCUPATION_____ EMPLOYER_____

EMERGENCY CONTACT_____ PHONE#_____

REFERRED BY_____

PRIMARY CARE PHYSICIAN_____ LAST VISIT _____

INSURANCE-REIMBURSEMENT INFORMATION & AUTHORIZATION

WE NEED TO COPY YOUR INSURANCE CARD(S)

INSURANCE: HMO_____; PPO_____; PRIVATE_____; MEDICARE_____; MEDICAID/PUBLIC AID_____;
WORKMEN'S COMP_____; NONE _____.

(ALL HMO PATIENTS MUST HAVE A CURRENT REFERRAL FROM THEIR PRIMARY CARE PHYSICAN AND ALL MEDICAID/PUBLIC AID PATIENTS MUST HAVE A CURRENT CARD/LETTER TO BE SEEN. ALL COPAYS ARE DUE AT TIME OF SERVICE)

I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS INSURANCE CLAIMS. I ALSO REQUEST PAYMENT OF GOVERNMENT OR INSURANCE BENEFITS EITHER TO MYSELF OR THE PARTY THAT ACCEPTS ASSIGNMENT. I AUTHORIZE PAYMENTS DIRECTLY TO DR. THOMAS A. BUIVIDAS AND/OR THE ARCHER FOOT & ANKLE SURGICAL FACILITY.

AUTHORIZED SIGNATURE_____DATE_____

PERSON FINANCIALLY RESPONSIBLE (IF OTHER THAN ABOVE):

NAME_____ RELATIONSHIP_____

EMPLOYER_____ SOC.SEC#_____

AREA CODE & PHONE# HOME_____ WORK_____

GENERALIZED CONSENT TO TREAT

I HEREBY GIVE PERMISSION TO DR. BUIVIDAS TO ADMINISTER TREATMENT & PERFORM SUCH GENERAL PROCEDURES AS DEEMED NECESSARY FOR THE DISGNOSIS &/OR TREATMENT OF FOOT/ANKLE CONDITION(S) ON THE ABOVE NAMED PATIENT.

AUTHORIZED SIGNATURE_____ DATE_____

ARCHER FOOT AND ANKLE CLINIC PLEASE PRINT & CHECK THE FOLLOWING PATIENT INFORMATION FOR OUR RECORDS.

MEDICAL HISTORY **NAME** _____ **DATE** _____

AGE _____ **RACE** _____ **SEX** _____ **HEIGHT** _____ **WEIGHT** _____

WHAT IS THE FOOT/ANKLE PROBLEM THAT YOU ARE HERE FOR? _____

_____

HOW LONG HAS IT BOTHERED YOU? _____

ANY PREVIOUS TREATMENT? _____

ANY OTHER PROBLEMS? _____

PLEASE CHECK PAST OR PRESENT CONDITIONS THAT APPLY TO YOU

_____ **ARTHRITIS/JOINT PROBLEMS** _____
_____ **BREATHING/LUNG PROBLEMS** _____
_____ **BACK/SPINE PROBLEMS** _____
_____ **BLOOD CLOTS** _____
_____ **BLOOD DISORDERS/ANEMIA** _____
_____ **BLOOD THINNERS** _____
_____ **BLEEDING PROBLEMS** _____
_____ **BONE PROBLEMS** _____
_____ **CANCER** _____
_____ **CHRONIC PAIN** _____
_____ **CIRCULATION PROBLEMS** _____
_____ **CURRENT DOCTOR CARE** _____
_____ **CURRENTLY PREGNANT** _____
_____ **DIABETES** _____
_____ **DIABETIC NEUROPATHY** _____
_____ **EYE/EAR/NOSE/THROAT PROBLEMS** _____
_____ **FATIGUE** _____
_____ **HEART CONDITION** _____
_____ **HIGH BLOOD PRESSURE** _____
_____ **INTESTINAL PROBLEMS** _____
_____ **INHERITED CONDITIONS** _____
_____ **INFECTIOUS DISEASES** _____
_____ **LEG/FOOT CRAMPS** _____
_____ **LIVER PROBLEMS** _____
_____ **MUSCLE PROBLEMS** _____
_____ **MENTAL HEALTH CONDITION** _____
_____ **NERVE\NEUROLOGICAL PROBLEM** _____
_____ **PODIATRY CARE** _____
_____ **SKIN DISORDERS** _____
_____ **THYROID PROBLEMS** _____
_____ **URINARY/KIDNEY DISORDERS** _____
_____ **VARICOSE VEINS** _____
_____ **SEIZURE DISORDERS** _____
_____ **SLEEP PROBLEMS** _____
_____ **WALKING PROBLEMS** _____
_____ **WEIGHT PROBLEMS** _____
_____ **OTHER CONDITIONS/PROBLEMS** _____

LIST PREVIOUS SURGERIES/HOSPITALIZATIONS _____

_____

_____

LIST CURRENT MEDICATIONS & DOSES _____

_____

LIST ALLERGIES/SENSITIVITIES_____

HABITS (HOW MUCH & HOW OFTEN) TOBACCO _____ **ALCOHOL** _____

SIGNATURE _____ **DOCTOR'S SIGNATURE** _____