PATIENT MEDICAL HISTORY Page 1

Name:_____ Birthdate: _____

Gender: _____ Weight: _____ Height: _____ Shoe size: _____

Bunion	Hammertoe	Heel Pain
Location: LEFT and/or RIGHT	**Location: LEFT and/or RIGHT**	**Location: LEFT and/or RIGHT**
□ Top □ Outside □ Bottom □ Toes □ Inside	□ Top □ Outside □ Bottom □ Toes □ Inside	□ Top □ Outside □ Bottom □ Toes □ Inside
Describe the pain:	**Describe the pain:**	**Describe the pain:**
□ Sharp □ Dull □ Throbbing □ Burning □ Radiating □ Numbness	□ Sharp □ Dull □ Throbbing □ Burning □ Radiating □ Numbness	□ Sharp □ Dull □ Throbbing □ Burning □ Radiating □ Numbness
How long has this been a concern?	**How long has this been a concern?**	**How long has this been a concern?**
□ _____ Days □ _____ Months □ _____ Weeks □ _____ Years	□ _____ Days □ _____ Months □ _____ Weeks □ _____ Years	□ _____ Days □ _____ Months □ _____ Weeks □ _____ Years
Pain scale:	**Pain scale:**	**Pain scale:**
□ 0 – no pain □ 2 –mild pain □ 4 – moderate pain □ 6 – severe pain □ 8 – very severe pain □ 10- worst possible pain	□ 0 – no pain □ 2 –mild pain □ 4 – moderate pain □ 6 – severe pain □ 8 – very severe pain □ 10- worst possible pain	□ 0 – no pain □ 2 –mild pain □ 4 – moderate pain □ 6 – severe pain □ 8 – very severe pain □ 10- worst possible pain

What conservative methods have you tried? (For a minimum of 12 weeks) Date

□ Rest
□ Ice/heat
□ Wide shoes/ shoe modification/inserts/ toe pads/ spacers/ bunion pad
□ Foot soaks
□ Pain relievers
□ Steroid shots Date: _____
□ Physical therapy Date: _____
□ Trouble walking/moving without discomfort
□ Other

_____

WHAT AGGRAVATES THE PAIN?

_____

_____

WHAT RELIEVES THE PAIN?

_____

_____

Any past foot surgery _____ Date:_____

SIGNATURE: _____ **DATE:** _____

PATIENT MEDICAL HISTORY Page 2

Name: _____ Birthdate: _____

ALLERGIES

□ Codeine □ Penicillin □ Keflex □ Aspirin □ Sulfa □ Lidocaine □ Neosporin □ Adhesive tape □ Iodine

Foods_____ Other _____ □ NO KNOWN ALLERGY

Unlisted Medications_____

Medications and supplements

Name _____ Dose_____ _____

Name _____ Dose_____ _____

Name _____ Dose_____ _____

Name _____ Dose_____ _____

Name _____ Dose_____ _____

Name _____ Dose_____ _____

PHARMACY

Name _____ Phone _____ City / State _____

FAMILY PHYSICIAN

Name _____ Phone _____ City / State _____

MEDICAL HISTORY

DO YOU SMOKE? _____ DO YOU DRINK? _____

	YOU	FAMILY		YOU	FAMILY		YOU	FAMILY
Alcoholism	____	____	High Cholesterol	____	____	Poor Circulation	____	____
Arthritis	____	____	HIV/AIDS	____	____	Rheumatoid Arthritis	____	____
Blood Clots	____	____	Hypertension	____	____	Seizures	____	____
Cancer	____	____	Kidney Disease	____	____	Stroke	____	____
COPD/Asthma	____	____	Liver Disease/Hepatitis	____	____	Thyroid Disease	____	____
Diabetes	____	____	Mental Health Concerns	____	____	Tobacco Use	____	____
Epilepsy	____	____	Migraines	____	____	Tuberculosis	____	____
Fibromyalgia	____	____	MRSA/VRSA	____	____	Varicose veins	____	____
Gout	____	____	Multiple Sclerosis	____	____	VRE	____	____
Heart Attack	____	____	Nerve problems	____	____	Other	____	____
Heart Disease	____	____	Pacemaker/Defibrillator	____	____			

For each checked above explain: _____

_____

List any other medical conditions not listed above: _____

Past Surgical History: _____

_____

SIGNATURE: _____ **DATE:** _____

PATIENT REGISTRATION

Name: _____ Birthdate: _____

Social Security Number: _____

SIGNATURE: _____ **DATE:** _____

Address: _____

City: _____ State: _____ Zip Code: _____

Email: _____

Home Phone: _____ Cell Phone: _____

Employer: _____ Work Phone: _____

Marital Status: □ Single □ Married □ Divorced □ Widowed Maiden Name_____

Race (optional): □ Caucasian □ African American □ Asian □ Native Hawaiian/Pacific Islander □ American Indian/Alaskan Native □ Declined

Ethnicity (optional): □ Hispanic or Latino □ Non-Hispanic or Latino □ Declined

Person To Contact In Case Of Emergency

Name_____ Relationship_____ Phone_____

How did you hear about us?

□ TV □ Newspaper □ Web search □ Other

□ Patient Referral _____ □ Doctor Referral _____

I hereby authorize Northwest Surgery Center and Dr Brant McCartan to furnish my insurance carrier all information that my insurance company may request concerning my illness or injury. I hereby assign to Northwest Surgery Center and Dr Brant McCartan all sums which are now payable or may hereafter become payable to me from the above insurance company and/or surgical expenses incurred by me and understand that I am legally responsible for any charges made by the above for medical and/or surgical services rendered to me which are in excess of the sums covered by this assignment. I hereby understand that any sums made payable to me by the insurance company and not returned to Northwest Surgery Center and Dr Brant McCartan after 30 days upon receipt, my account will be referred to a collection agency for payment and or legal action.

Patient or Guarantor's Signature_____ **Date**_____

I hereby authorize Northwest Surgery Center the right to use any pre or post-operative foot/feet photos or x-rays for any lawful purpose, which may include, but is not limited to, Northwest Surgery Center website, before and after samples on display at the surgery center, medical case studies, social media (and associated social media sites), etc. Northwest Surgery Center agrees to have all identifying information excluded from all such photos or x-rays so that patient identity remains anonymous.

ACCEPT – photos to be taken and use for medical use and terms listed above. □
AUTHORIZE – before and after photos to be taken for medical records ONLY. □

Patient or Guarantor's Signature_____ **Date**_____

HIPAA Privacy

I agree / wish to be contacted in the following manner (check all that apply):

- ☐ Home/Cell Telephone
- ☐ O.K. to leave message with detailed
- ☐ Leave message with call-back number
- ☐ Text Messages
- ☐ Written Communication
- ☐ O.K. to mail to mail to my home address
- ☐ O.K. to mail to my work/office address

I agree that my protected health information can be discussed/disclosed to the following person:

Name _____ Relationship _____ Phone # _____

Patient or Guarantor's Signature_____ **Date**_____

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.
The Privacy Rule generally requires health care providers to take reasonable steps to limit the use or disclosure of, and requests for PHI to the minimum necessary to accomplish the intended purpose. These provisions do not apply to uses of disclosures made pursuant to an authorization requested by the individual.
Healthcare entities must keep records of PHI disclosures. Information provided below, if completed properly, will constitute an adequate record.
Note: Users and Disclosures for TPO may be permitted without prior consent in an emergency.

FOR OFFICE USE ONLY

Record of Disclosures of Protected Health Information

Date	Disclosed to Whom Address or fax number	(A)	Description of Disclosure/Purpose of Disclosure	By Whom Disclosed	(B)	(C)

A. Check this box if the disclosure is authorized

B. Write in box: T= Treatment records P= Payment Information

C. Enter how disclosure was made: F= Fax P=Phone E=Email M=Mail O=Other

ACKNOWLEDGMENT OF RECEIPT OF PRIVACY NOTICE

I acknowledge that I have received the attached Privacy Notice.

Patient or Guarantor's Signature_____ **Date**_____