PATIENT MEDICAL HISTORY

Name: _____ Birthdate: _____ Age: _____

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

PRIMARY CONCERN □ left □ right □ both

□ Bunion □ Hammertoe □ Plantar fasciitis
□ Heel pain □ Nail fungus □ Foot/ankle injury
□ Neuroma □ Plantar warts □ Ingrown toenail
□ Corn/callus □ 2nd opinion □ Work related injury
□ Other_____

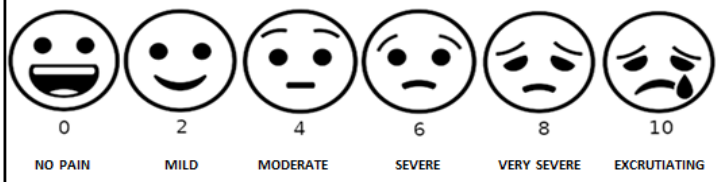
DESCRIBE THE PAIN
□ Sharp □ Dull □ Throbbing □ Burning
□ Radiating □ Numbness

LOCATION
□ Top □ Bottom □ Inside □ Outside
□ Toes □ Webs □ Nails

HOW LONG HAS THIS BEEN A CONCERN
□ Days □ Weeks □ Months □ Years
How Many? _____

What conservative methods have you tried?
□ Rest
□ Ice/Heat
□ Shoe modification/Inserts
□ Wide shoes
□ Toe pads/Spacers
□ Foot soaks
□ Pain relievers
□ Steroid shots
□ Physical therapy
□ Other _____

PAIN SCALE – circle one



ALLERGIES
□ Codeine □ Penicillin □ Keflex □ Aspirin □ Sulfa □ Lidocaine □ Neosporin □ Adhesive tape
□ Iodine □ Latex □ Local Anesthetics □ Foods_____ □ Other: _____

□ **NO KNOWN ALLERGY**

PHARMACY:
Name _____ Phone _____ City / State _____

FAMILY PHYSICIAN:
Name _____ Phone _____ City / State _____

CURRENT MEDICATIONS:

_____

MEDICAL HISTORY

	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/C.DIFF/VRSA			Varicose veins		
Gout			Multiple Sclerosis			**Vitamin D Deficiency**		
VRE			Heart Attack			Nerve problems		
Heart Disease			Pacemaker/Defibrillator			Other		

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: _____

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 Jordan Sullivan 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 Jordan Sullivan 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 Jordan Sullivan 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, etc. Northwest Surgery Center agrees to have all identifying information excluded from all such photos or x-rays so that patient identity remains anonymous.

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.

ACKNOWLEDGMENT OF RECEIPT OF PRIVACY NOTICE

I acknowledge that I have received the attached Privacy Notice.

Patient or Guarantor's Signature_____ Date_____