Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Birthdate: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PATIENT MEDICAL HISTORY Page 1**

|  |  |  |
| --- | --- | --- |
| **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 |

Gender: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Weight: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Height: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Shoe size: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

**WHAT AGGRIVATES THE PAIN?**

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

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

**WHAT RELEIVES THE PAIN?**

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

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

**What conservative methods have you tried?**

**(For a minimum of 12 weeks)**

□ Rest

□ Ice/heat

□ Wide shoes/ shoe modification/inserts/ toe pads/ spacers/ bunion pad

□ Foot soaks

□ Pain relievers

□ Steroid shots

□ Physical therapy

□ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Any past foot surgery ­­­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Birthdate: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PATIENT MEDICAL HISTORY Page 2**

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

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):**

 Written Communication

 O.K. to mail to mail to my home address

 O.K. to mail to my work/office address

 Home/Cell Telephone

 O.K. to leave message with detailed

 Leave message with call-back number

 Text Messages

**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) |
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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\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**