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_____

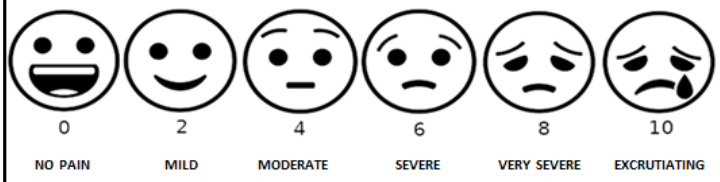
DESCRIBE THE PAIN
□ Sharp □ Dull □ Throbbing □ Burning
□ Radiating □ Numbness

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: o Single o Married o Divorced o Widowed Maiden Name:

How did you hear about us?

o TV o Newspaper o Web search o Other

o Patient Referral: _____ o Doctor Referral:

PERSON TO CONTACT IN CASE OF EMERGENCY

Name: _____ Relationship:_____ Phone:

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_____