PATIENT MEDICAL HISTORY

Name:________________ Birthdate:____________ Age:__________

Gender:__________ Weight:__________ Height:__________ Shoe Size:__________

Allergies/Reactions (including medication, environment, food, metal, and animal):________________

________________ ☐ N/A

PRIMARY CONCERN ___Left ___Right

___Bunion
___Hammertoe
___Neuroma
___Heel Pain
___Plantar fasciitis
___Corn/Callus
Other ______________

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
___Foot soaks
___Pain relievers
___Steroid shots
___Physical therapy
___Other ______________

MEDICAL HISTORY

___Alcoholism
___Arthritis
___Blood Clots
___Cancer
___COPD/Asthma
___Diabetes
___Fibromyalgia
___Gout
___Heart Disease
___High Cholesterol
___HIV/AIDS
___Hypertension
___Kidney Disease
___Rheumatoid Arthritis
___Seizures
___Stroke
___Thyroid Disease
___Tobacco Use
___Tuberculosis
___Vitamin D Deficiency
___Nerve Problems
___Mental Health Concerns
___MRSA/C.DIFF/VRSA
___Multiple Sclerosis
___Pacemaker/Defibrillator
___Liver Disease/Hepatitis

Other ______________

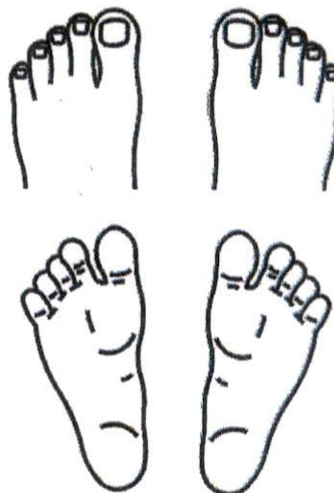
DESCRIBE THE PAIN ON YOUR WORST DAY

___Sharp
___Dull
___Throbbing
___Burning
___Radiating
___Numbness

Circle one

Mild
Moderate
Severe

CIRCLE YOUR AREAS OF CONCERN



CURRENT MEDICATIONS ☐ N/A

____
____
____
____

PAST SURGICAL HISTORY ☐ N/A

____
____
____
____

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 The Bunion Cure at 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 The Bunion Cure at 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 The Bunion Cure at 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 The Bunion Cure at Northwest Surgery Center the right to use any pre or post-operative foot/feet photos, videos or x-rays for any lawful purpose, which may include, but is not limited to, The Bunion Cure at Northwest Surgery Center website, before and after samples on display at the surgery center, medical case studies, etc. The Bunion Cure at Northwest Surgery Center agrees to have all identifying information excluded from all such photos, videos 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**______________