PATIENT INFORMATION (please print)

Date_____

☐ Single	Race	Birthdate
☐ Married	Ethnicity	Age
☐ Widowed	Religion	Height
☐ Divorced	SEX: ☐ M ☐ F	Weight

Social Security #_____

Patient Name _____
Last First Middle Initial

Address _____
Number & Street City State Zip

• **PHONE** Home (____)_____ Cell (____)_____

Occupation (____)_____Employer(____)_____Business(____)_____

Emergency Contact (____)_____ Relationship & Name_____

• **EMAIL** _____

• **Primary Insurance** _____

Subscriber Name_____**Subscriber Birthdate**_____

SS Number_____

• **Secondary Insurance** _____

Subscriber Name_____**Susbcriber Birthdate**_____

SS Number_____

Who referred you to this office? _____☐DR. ☐ Attorney ☐Self

Address_____
Number & Street City State Zip

Phone (____)_____ Fax (____)_____

Family Doctor_____

Address_____
Number & Street City State Zip

Phone (____)_____ Fax (____)_____

Were you seen in an emergency room for this problem? ☐Yes ☐No

Hospital_____**Date**_____

In this section, check the **ONE BOX** that best describes how your problem started, then answer the questions. Use as much space as needed in the comment section.

COMMENTS

☐ **No Injury** - onset was ☐gradual or ☐sudden

Why do you think it started?

☐ **Injury** ☐Accident or ☐Sport ☐Not auto or work

Where & how did it happen?

☐ **Injury at work** Date_____

From a ☐lift ☐twist ☐fall ☐bend ☐pull ☐reach

☐ **Auto accident** Date _____

How was your vehicle hit?

PATIENT NAME:_____ **DOB:**_____

What body part is involved? _____ ☐ right ☐ left

What is the main reason for this visit? ☐ pain ☐ numbness ☐ weakness ☐ swelling ☐ stiffness

☐ other _____ When did it start? _____(date)

Have you had a problem like this before? ☐ yes ☐ no If yes, when: _____

On a scale of 1-10 (10 is the worst), How severe is your pain? 0 1 2 3 4 5 6 7 8 9 10 (circle)

What is the quality of the pain? ☐ sharp ☐ dull ☐ stabbing ☐ throbbing ☐ aching ☐ burning

The pain is: ☐ constant ☐ comes and goes Does your pain wake you from sleep? ☐ yes ☐ no

Do you have ☐ swelling ☐ bruising ☐ numbness ☐ tingling ☐ weakness ☐ loss of bowel/bladder

Since my problem started, it is ☐ getting better ☐ getting worse ☐ unchanged

What makes your symptoms worse? ☐ standing ☐ walking ☐ squatting ☐ exercising ☐ twisting

☐ sitting ☐ stairs ☐ lifting ☐ kneeling ☐ bending ☐ coughing ☐ sneezing ☐ lying in bed

What makes your symptoms **better**? ☐ rest ☐ elevation ☐ ice ☐ heat ☐ other _____

Have you had any of these treatments? Injection: ☐ yes ☐ no brace: ☐ yes ☐ no

physical therapy: ☐ yes ☐ no cane/crutch: ☐ yes ☐ no

What tests have you had for this problem? ☐ x-rays ☐ MRI ☐ CT scan ☐ bone scan ☐ EMG

Have you had surgery for a problem in the same area either recently or in the past? ☐yes ☐no

If yes, previous surgery and date: _____

Current work status: ☐ regular ☐ light duty (how long?____) ☐ not working due to this problem

☐ disabled ☐ retired ☐ student

When is the last date you worked your regular job? _____

Are you currently receiving or do you plan to apply for: disability ☐ yes ☐ no

workers' comp ☐ yes ☐ no unemployment ☐ yes ☐no

MEDICATION RECORD

Patient Name _____ DOB _____

Pharmacy _____ Phone _____ Fax _____

Address _____

ALLERGIES

List all drug allergies	List reaction

CURRENT MEDICATION

Please Include Supplements and Vitamins

Medication	Strength	How many times daily

❒ Flu Vaccination - Date ____/____/_____ ❒ Pneumonia Vaccination ____/____/____

Patient Signature _____ Date _____

Patient Name _____ DOB _____

Social History: Please respond to the following by Placing Mark inside Circles. ✓

Substance Use: Do you use

_____Tobacco ? ○ Yes ○ No ○ Former Type:_____: ○ Light ○ Medium ○ Heavy

_____Alcohol ?

_____Caffeine ?

_____Illicit Drugs ?

_____I do not use any of the above.

Hand dominance? ○ Right Handed ○ Left Handed

Females Only: Could you be pregnant ? ○ Yes ○ No

Allergies: Do you have allergies to any of the following medications or substances. ✓

○ No Known Allergies	○ Aspirin	○ Tegretol
○ Penicillin	○ Amoxil	○ Bactrim
○ Codeines	○ Keflex	○ Pediazole
○ Sulpha Drugs	○ Cefzil	○ Novacaine
○ Iodine Shellfish	○ Ceftin	○ Novacaine
○ Ampicillin	○ Suprax	○ Insulin
○ Vantin	○ Septra	○ Lidocane
○ Depakene	○ Lamictal	

Other Allergies:

○ Latex ○ IVP/X-RY DYE ○ Metal ○ Egg / Avian (Bird)

List any other allergies in this box

Patient Name _____ DOB _____

Medical Disorders:

If you have had any of the following. Place ✓ mark inside circle.

- ○ No Medical History
- ○ AIDS / HIV
- ○ Alcoholism
- ○ Alzheimer's
- ○ Anemia
- ○ Rheumatoid Arthritis
- ○ Asthma
- ○ Blood Clot - Leg
- ○ Blood Clot-Lung
- ○ Other Disease (list below)
- ○ Stroke
- ○ Cancer Breast
- ○ Cancer Colon
- ○ Cancer Lung
- ○ Cancer Prostate
- ○ COPD
- ○ Depression
- ○ Diabetes
- ○ Drug Abuse
- ○ Sleep Apnea
- ○ Gout
- ○ Heart Attack
- ○ High Blood Pressure
- ○ Hepatitis
- ○ Kidney Disease
- ○ Osteoarthritis
- ○ Seizures
- ○ Ulcers, Bleeding

Blood thinners (Coumadin, Plavix, Aspirin, etc.)

Surgical History:

If you have had any of the following. Place ✓ mark inside circle and list <u>Date</u> diagnosed.

- ○ No surgical history reported
- ○ Carpal Tunnel Left Wrist ___/___/___
- ○ Arthroscopy Left Elbow ___/___/___
- ○ Arthroscopy Left Shoulder ___/___/___
- ○ Arthroscopy Left Ankle ___/___/___
- ○ Arthroscopy Left Knee ___/___/___
- ○ Arthroscopy Left Hip ___/___/___
- ○ Left Hip Replacement ___/___/___
- ○ Left Knee Replacement ___/___/___
- ○ Mastectomy - Left ___/___/___
- ○ Spinal Fusion ___/___/___
- ○ Other Surgery *(list in the box below)*
- ○ Cardiac (Heart) ___/___/___
- ○ Carpal Tunnel Right Wrist ___/___/___
- ○ Arthroscopy Right Elbow ___/___/___
- ○ Arthroscopy Right Shoulder ___/___/___
- ○ Arthroscopy Right Ankle ___/___/___
- ○ Arthroscopy Right Knee ___/___/___
- ○ Arthroscopy Right Hip ___/___/___
- ○ Right Hip Replacement ___/___/___
- ○ Right Knee Replacement ___/___/___
- ○ Mastectomy - Right ___/___/___
- ○ Laminectomy ___/___/___
- ○ Fracture Surgery ___/___/___

List any other surgeries

Patient Name:

Review of Systems: If you have any of the following, Please Place Mark inside Circles

Constitutional
- O Weight Loss/Gain
- O Weakness
- O Fatigue
- O Fever

Eyes
- O Glasses or Contacts
- O Blurred Vision
- O Glaucoma
- O Cataracts
- O Excessive Tearing

Ear Nose Mouth Throat:
- O Ears Ringing
- O Earaches
- O Hearing Aid
- O Frequent Colds
- O Nasal Discharge
- O Hay Fever
- O Nosebleeds
- O Dentures
- O Bleeding Gums
- O Frequent Sore throats

Endocrine
- O Thyroid Trouble
- O Excessive Sweating
- O Excessive thirst

Cardiovascular
- O High Blood Pressure
- O Chest Pain
- O Rheumatic Fever
- O Palpitations
- O Has Pacemaker

Skin
- O Rashes
- O Sores
- O Lumps
- O Dryness
- O Itching

Neurological
- O Headache
- O Dizziness
- O Seizures
- O Loss of Sensation
- O Vertigo

Gastrointestinal
- O Heart Burn
- O Rectal Bleeding
- O Abdominal Pain
- O Gallbladder trouble
- O Hepatitis

Immunologic
- O Reactions to Drugs
- O Skin Rashes
- O Reactions to Foods

Musculoskeletal
- O Joint Pain
- O Arthritis
- O Muscular Weakness
- O Stiffness
- O Muscular Pain

Blood or Lymph
- O Anemia
- O Easy Bruising
- O Easy Bleeding
- O Swollen Glands

Respiratory
- O Shortness of Breath
- O Cough
- O Wheezing
- O Asthma
- O Bronchitis

Genitourinary
- O Blood in Urine
- O Urinary Infections
- O Kidney Stones
- O Burning Urination
- O Sexual Disease

Psychological
- O Nervousness
- O Depression
- O Mood Changes

(b)

Patient Name _____ DOB _____

Family History:

If any Family Member below has any of the following history, place ✓ mark inside Circles.

FATHER Medical History

- ○ AIDS / HIV
- ○ Anemia
- ○ Blood Clots
- ○ Cancer - Type: _____
- ○ Coronary Artery Disease
- ○ Other _____
- ○ Diabetes
- ○ Gout
- ○ Heart Attack
- ○ Hemophilia
- ○ Hypertension
- ○ Kidney
- ○ Liver Disease
- ○ Muscle Disease
- ○ Osteoporosis
- ○ Rheumatoid Arthritis
- ○ Osteoarthritis

MOTHER Medical History

- ○ AIDS / HIV
- ○ Anemia
- ○ Blood Clots
- ○ Cancer - Type: _____
- ○ Coronary Artery Disease
- ○ Other _____
- ○ Diabetes
- ○ Gout
- ○ Heart Attack
- ○ Hemophilia
- ○ Hypertension
- ○ Kidney
- ○ Liver Disease
- ○ Muscle Disease
- ○ Osteoporosis
- ○ Rheumatoid Arthritis
- ○ Osteoarthritis

SIBLING Medical History

- ○ AIDS / HIV
- ○ Anemia
- ○ Blood Clots
- ○ Cancer - Type: _____
- ○ Coronary Artery Disease
- ○ Other _____
- ○ Diabetes
- ○ Gout
- ○ Heart Attack
- ○ Hemophilia
- ○ Hypertension
- ○ Kidney
- ○ Liver Disease
- ○ Muscle Disease
- ○ Osteoporosis
- ○ Rheumatoid Arthritis
- ○ Osteoarthritis

Patient Name: _____ DOB: _____

AUTHORIZATION FOR TREATMENT AND PAYMENT

The above information is true to the best of my knowledge. I hereby authorize treatment of the above named person and acknowledge to that I am able to read, write and understand English and if not, I have brought an adult with me who is able to interpret on my behalf. I authorize Lawrence M. Fallat, DPM, PC and Associates, to furnish information to my current or future insurance carrier(s) any information needed for the purposes of securing payment for services provide and assign all payment for services provided to the physician listed above all. I understand that I am financially responsible for any amounts not covered by my insurance and a co-pay, co-insurance, balance or deductible will be collected before I am treated by the physician. Any amounts owing after my insurance has paid will be remitted promptly upon receipt of a statement. It is my responsibility to obtain any authorization required prior to seeing the specialist and I may not be seen without it if required due to insurance.

PATIENT/GUARDIAN SIGNATURE: _____ **DATE:** _____

_____

PATIENT CONTACT INFORMATION

Many of our patients allow family members such as their spouse, parents or others to call and request medical or billing information. Under the requirements of HIPAA we are only allowed to release information without the patient's consent for specific uses related to treatment, payment and operations as outlined in our privacy notice. If you wish for us to release/discuss your medical or billing information with other individuals you must sign this form. You have the right to revoke this request in person or writing at any time.

Home Telephone (#_____)

( ) It is okay to leave message with detailed information

( ) Leave message with call back number only

Work Telephone (#_____)

( ) It is okay to leave message with detailed information

( ) Leave message with call back number only

Email Address (Email:_____)

( ) It is okay for the doctor to communicate with me via email

( ) it is okay for the staff to communicate with me via email

Text Message (#_____)

( ) It is okay to text message me

Other Restriction(s): _____

I hereby give permission to authorize Lawrence M. Fallat, DPM, PC and Associates to discuss my treatment or bill with the following individuals (check all that apply):

( )**Spouse Name**:_____

Contact #_____

( )**Child Name**:_____

Contact #_____

( )**Parent Name**:_____

>>

Contact #_____

( )**Other & Relationship**:_____

Contact #_____

( ) The above named individuals have my permission to pick up forms, samples, medical equipment or prescriptions on my behalf. I understand that ID may be requested by the staff before these items are released. Please be advised that in an emergency situation, or if we are unable to reach you for urgent medical matters through the numbers provided, we will contact the emergency contact listed on the Patient Information Form.

PATIENT/GUARDIAN SIGNATURE: _____ **DATE:** _____

( ) ***I hereby give permission to authorize LMF DPM & Associates to discuss my treatment with any of my health care providers either verbally, written, or electronically.***

Signature _____ ***Date*** _____

OPT Out _____ ***Date*** _____

For office use:

( ) On _____, 20_____, I presented this Acknowledgement of Receipt of Notice of Privacy form to the above names patient and / or their guardian.

( ) Parent/guardian returned; staff witness below

( ) The patient refused to provide signature when requested

( ) Other (list): _____

Office Staff Signature _____ Date _____