

Patient Forms

Basic Information

Full Name

First

Middle

Last

Suffix

Sex Male Female Unknown

Date of Birth

Primary Phone Home Mobile Work

Phone Number

Email

Social Security Number

Address Line 1

Address Line 2

City

State

Zip

Marital Status

Maiden Last

Driver's License State

Driver's License #

Demographics

Hispanic or Latino? Yes No Decline to Specify

Ethnicity

Race

Language

Emergency Contact

Relationship to Contact

Full Name

First

Middle

Last

Primary Phone Home Mobile Work

Phone Number

Email

Address Line 1

Address Line 2

City

State

Zip

Additional information

Please list your preferred pharmacies in order of preference.

Pharmacy name

Pharmacy address

Employer: _____

Job description: _____

Please describe your foot and/or ankle condition(s)/prior treatment: _____

HEIGHT: _____ **WEIGHT:** _____ **Shoe size:** _____

Past Medical History

Please check all that apply:

Head

- Trauma

Eyes

- blindness
- Cataracts
- Glaucoma
- Wears glasses/ contacts

Ears

- Hearing aids

Nose/Sinuses

- Allergic Rhinitis
- Sinus Infections

Mouth/Throat/Teeth

- Dentures

Cardiovascular

- Aneurysm
- Angina
- DVT
- Dysrhythmia
- HTN
- Murmur
- Myocardial infarction
- Other heart disease

Respiratory

- Asthma
- Bronchitis
- COPD -
Bronchitis/Emphysema
- Pleuritis
- Pneumonia

Gastrointestinal

- Cirrhosis
- GERD
- Gallbladder disease
- Heartburn
- Hemorrhoids
- Hepatitis
- Hiatal hernia
- Jaundice
- Ulcer
-

Genitourinary

- Hernia
- Incontinence
- Nephrolithiasis
- Other kidney disease
- STDs
- UTI(s)

Endocrine

- Goiter
- Hyperlipidemia
- Hypothyroidism
- Thyroid disease
- Thyroiditis
- Type 1 DM
- Type 2 DM

Heme/Onc

- Anemia
- Cancer

Infectious

- HIV
- STDs
- Tuberculosis (dz)
- Tuberculosis (exposure)

Musculoskeletal

- Arthritis
- Gout
- M/S injury

Skin

- Dermatitis
- Mole(s)
- Other skin condition(s)
- Psoriasis

Neurological

- Epilepsy
- Seizures
- Severe headaches,
migraines
- Stroke
- TIA

Psychiatric

- Bipolar disorder
- Depression
- Hallucinations,
delusions
- Suicidal ideation
- Suicide attempts

Other Medical Conditions:

Primary Care Physician: _____

Name: _____ DOB: _____ Date: _____

Family History

Have any blood relatives ever had the following? Please circle yes or no. If so, please indicate their relationship to you in the column below.

| | | Father | Mother | Brother | Sister | Son | Daughter |
|----------------------------------|--------|--------|--------|---------|--------|-----|----------|
| Alive or Deceased | | | | | | | |
| Arthritis | Yes No | | | | | | |
| Asthma | Yes No | | | | | | |
| Blood Disease/Bleeding Disorder | Yes No | | | | | | |
| CAD < age 55 | Yes No | | | | | | |
| COPD | Yes No | | | | | | |
| Diabetes | Yes No | | | | | | |
| Heart Attack | Yes No | | | | | | |
| Heart Disease | Yes No | | | | | | |
| High Cholesterol | Yes No | | | | | | |
| High Blood pressure/Hypertension | Yes No | | | | | | |
| Mental Illness | Yes No | | | | | | |
| Osteoporosis | Yes No | | | | | | |
| Stroke | Yes No | | | | | | |
| Hepatitis | Yes No | | | | | | |
| Tuberculosis | Yes No | | | | | | |
| Cancer(s): | Yes No | | | | | | |
| Type of cancer: | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| Malignant Hyperthermia | Yes No | | | | | | |
| Unusual reaction to anesthesia | Yes No | | | | | | |
| Other Family History: | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |

Social History

Tobacco

- Current everyday smoker
- Current some day smoker
- Former smoker
- Heavy tobacco smoker
- Light tobacco smoker
- Never Smoker
- Smoker, current status unknown
- Unknown if ever smoked

Alcohol

- Do not drink
- Drink daily
- Frequently drink
- History of Alcoholism
- Occasional drink

Cardiovascular

- Eat healthy meals
- Regular exercise
- Take daily aspirin

Drug Abuse

- IVDU
- Illicit drug use
- No illicit drug use

Name:

DOB:

Date:

Patient name: _____ Date of Birth: _____

General Consent for Treatment
Assignment of Benefits
Patient Responsibility for Payment

I, the undersigned, being either the patient or the patient's legally authorized representative, do hereby:

GENERAL CONSENT FOR TREATMENT

- Consent to medical treatment and/or evaluation, including but not limited to laboratory and x-ray examinations, and minor in office procedures.

ASSIGNMENT OF BENEFITS

- Assign all benefits under any insurance or health benefit plan for payment for medical services rendered by Dr. Barry White to Coastal Maine Foot and Ankle.

PATIENT RESPONSIBILITY FOR PAYMENT

- Accept financial responsibility for any amount not paid by insurance or other health plans in accordance with Coastal Maine Foot and Ankle's "Patient Financial Policy".

REQUIRED FORMS

I have received a copy of the "Patient Financial Policy/Patient Rights and Responsibilities: and a copy of the Coastal Maine Foot and Ankle "Notice of Privacy Practices". I understand that it is my responsibility to read the information and ask any questions that I may have. I further understand that current copies of both documents will be available at all times for my review. I understand that this document remains in effect for as long as I continue to visit Coastal Maine Foot and Ankle, unless specifically rescinded in writing.

 Patient signature Date

 Legally authorized Representative Relationship
 (If patient is under the age of 18 or otherwise unable to consent)

List other authorized person(s) who may accompany or make treatment decisions for the minor patient in the absence of the above representative:

 Name Relationship

 Name Relationship