## PATIENT INFORMATION

Name:_____ Date of birth:_____ Age:_____
Home Phone no. (  )_____--_____,
Daytime phone number (  ) _____-_____ , Name of Work Place: _____
Home address:_____City_____State:_____Zip:_____
In case of emergency, notify:_____ Phone:(  ) _____-_____
Social Security No._____-____-_____ Sex: M / F Widow___Single___Married____ Divorced____
Medical Doctor:_____, town: _____Phone (  )____-_____
Former Foot Doctor:_____
How did you find us?(Family, Friend, Doctor, Yellow Pages, White Pages, Internet, etc.)_____

Parent of minor /Guardian (The person responsible for the payment): _____
Relationship: _____ Phone: (  ) _____
Home address: (  ) Same as above
_____ City_____ State:_____ Zip:_____

### INFORMATION OF INSURANCE AND POLICYHOLDER

Primary Insurance Co._____ Effective Date_____
Primary name of policy holder_____ DOB:_____
Social Security No._____ Relationship to patient:_____
Employer:_____ Home Phone:_____
Work Phone:_____ Secondary Insurance Co_____
Name of secondary policyholder:_____ Date of Birth for 2ndary:_____
Do you need pre-authorization (written referral from primary care physician) to see a specialist?: Yes/No

**PERMISSON/ Assignment of Benefits / Insurance Authorization**: I hereby give my permission to Dr. Song or his associate to administer treatment; and to perform such minor procedures as may be deemed necessary in the diagnosis and/or treatment of my foot condition. I authorize payment of benefits to Harpeth Foot & Ankle Center/ Dr. David I. Song on the account of expenses for the indicated services. I authorize release of any medial information necessary to process this claim. I verify that the above information and patient medical information I provided is correct to the best of my knowledge. I authorize the use of this form in all my insurance admissions, and I permit a copy of this authorization to be as valid as the original. I understand that I am financially responsible for all charges and services rendered on my behalf or my dependents, whether or not paid by insurance. I acknowledge that **"Notice of Privacy Practices"** is readily available, and copy of it is available to me by submitting a written request form.

**Delinquent account notice:** Delinquent accounts may be charged collection cost, court cost, attorney fees, and any other cost associated with the collection of this account. Interest shall accrue at a rate of 1.5% per month on the total delinquent balance.

I give my permission for pictures to be taken for editorial and/or promotional purposes.
I authorize to discuss or send my medical information to physicians under whom I was under care, or to physicians I am being referred to. I will notify in writing if I would like to limit the extent of medical release.

Patient (or guardian) Signature: X_____ Date_____

Patient Name MR# *(office use)* Date

PODIATRIC HISTORY AND PHYSICAL
HARPETH FOOT & ANKLE CENTER

**Age:** _____ **w/b/h/a** **m/f** **Referred by:** _____

**Reason for Visit:** _____

Location of pain/problem? **(include left and/or right)** _____

How long have you had symptoms? _____

Have you had an injury to this area? _____ If so, when? _____

Characteristics of problem: (please circle): pain dull ache throb shooting pain numbness tingling discolored

What makes it worse? _____ What makes it feel better? _____

Any previous treatment for this problem? Helped? _____

Other problems with feet? _____

**REVIEW OF SYSTEMS** circle yes or no to each item below

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| **Fever, chills** | yes | no | **Diabetic** | yes | no | **Weight gain/loss** | yes | no |
| **Night sweats** | yes | no | **Mood changes** | yes | no | **Headaches** | yes | no |
| **Vision changes** | yes | no | **Shortness of breath** | yes | no | **Chest pain** | yes | no |
| **Irregular heartbeat** | yes | no | **Limb swelling** | yes | no | **Stomach Ulcers** | yes | no |
| **Jaundice** | yes | no | **Frequent/painful urination** | yes | no | **Joint pain** | yes | no |
| **Anemia** | yes | no | **Night pain** | yes | no | **Bleeding disorder** | yes | no |
| **Blood Transfusion** | yes | no | **Pregnant/Nursing** | yes | no | **Back problems** | yes | no |
| **Do you heal timely** | yes | no | | | | | | |
| **Numbness in legs/feet** | yes | no | | | | | | |

**Do you require Prophylactic Antibiotics for ANY invasive procedures? Yes No If yes, explain** _____

**ALLERGIES to DRUGS:** ☐ **No known Allergies**

| | | | |
|---|---|---|---|
| **Penicillin** | yes | no | Others: _____ |
| **Codeine** | yes | no | _____ |
| **Sulfa** | yes | no | _____ |
| **Aspirin** | yes | no | _____ |

**CURRENT MEDICATIONS:** _____

_____
_____
_____
_____

**PAST MEDICAL HISTORY:** circle all that apply

**Diabetes: Type 1 Type 2 Asthma, Cancer, Depression**
**Heart Disease, HIV/AIDS, High Blood Pressure**
**Lung Disorder Neurological Disorder**
**Other:** _____

**SOCIAL HISTORY:**

**Do you smoke?** yes no
**Packs per day:** _____ **for** _____ **years?**
**Do you drink alcohol?** yes no
**History of Drugs?** yes no

**Please List any Surgeries you have had :** _____
( Please include date/year surgery was performed)

**FAMILY HISTORY:** check all health problems that your blood relatives have had, and then indicate your (the patient) relationship to that person.

**Diabetes** _____ **Cancer** _____
**Arthritis** _____ **Bleeding Disorder** _____
**Heart Disease** _____ **Osteoporosis** _____
**Other** _____

**OCCUPATION:**

**On your feet** _____ **% of the time at work?**
**Working as** _____
**Wearing what type of shoe?** _____

**Height:** **Weight:** **X** _____ / _____
**Patient signature** **Staff initials**