ST. LOUIS FOOT AND ANKLE INSTITUTE

Patient Contact Information

Name: _____ DOB: _____

Gender: □ Female □ Male □ Other _____ SSN: _____

Marital Status: □ Single □ Married □ Divorced □ Widowed □ Minor

Address: _____

City: _____ State: _____ Zip: _____

Email: _____

Home Phone #: _____ Cell Phone #: _____

Emergency Contact Information

Name: _____ Relationship: _____

Phone #: _____

I agree that STLFAI may contact me by phone, email, and/or text: □ Yes □ No

I authorize STLFAI to share information about my care electronically. □ Yes □ No

Primary Care Doctor

Name: _____ Phone: _____

Pharmacy Information

Name: _____ Phone: _____

Address: _____

Employment Information

Employer: _____ Occupation: _____

Address: _____ Phone: _____

Insurance Information

Primary Insurance: _____

Member ID: _____ Group #: _____

Policy Holder Name: _____ Relationship: □ Self □ Spouse □ Parent

Policy Holder DOB: _____ Policy Holder SSN: _____

Secondary Insurance: _____

Member ID: _____ Group #: _____

Policy Holder Name: _____ Relationship: □ Self □ Spouse □ Parent

Policy Holder DOB: _____ Policy Holder SSN: _____

ST. LOUIS FOOT AND ANKLE INSTITUTE

CERTIFICATION OF INSURANCE COVERAGE

I certify that I have insurance coverage stated above and assign directly to St. Louis Foot and Ankle Institute, LLC and Dr. Meghan Arnold all insurance benefits. I understand that I am financially responsible for all charges whether they are paid by insurance. I authorize the use of my signature on all insurance submissions. This consent does not expire unless I revoke it in writing.

ACKNOWLEDGEMENT OF FINANCIAL AND PAYMENT POLICY

I acknowledge that I was provided with a copy of the Financial Policies and that I have read (or had the opportunity to read if I so chose) and understood the Notice. I hereby authorize payment directly to St. Louis Foot and Ankle Institute, LLC of all insurance benefits otherwise payable to me for services rendered. I authorize the above doctor and/or provider or supplier of services and durable medical equipment in this office to release the information required to secure the payment or benefits. I authorize the use of this signature on all insurance submissions. This consent does not expire unless I revoke it in writing.

ACKNOWLEDGEMENT OF RECIEPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided with a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read if I so chose) and understood the Notice.

_____ _____

Patient or Authorized Representative Signature Date

ST. LOUIS FOOT AND ANKLE INSTITUTE

HIPAA Privacy and Release of Information Authorization

I hereby authorize St. Louis Foot and Ankle Institute, LLC., and its affiliates, its employees, and agents, to use and disclose protected health information (e.g., information relating to the diagnosis, treatment, claims payment, and health care services provided or to be provided to me and which identifies my name, address, social security number, Member ID number) for the purpose of helping me to resolve claims and health benefit coverage issues.

I understand that any personal health information or other information released to the person or organization identified above may be subject to re-disclosure by such person/organization and may no longer be protected by applicable federal and state privacy laws.

I understand that I have a right to revoke this authorization by providing written notice to STLFAI. However, this authorization may not be revoked if it's employees or agents have taken action on this authorization prior to receiving my written notice. I also understand that I have a right to have a copy of this authorization.

I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

I further understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my eligibility for benefits or enrollment or payment for or coverage of services.

I have been advised of this practice's Privacy Practices, Release of Billing Information policy, Assignment of Benefits policy, and grant the practice Medication History Authority.

By signing this form, I represent that I am the Member, or the legal representative of the Member identified above and if I am the legal representative I will provide written proof (e.g., Power of Attorney, living will, guardianship papers, etc.) that I am legally authorized to act on the Member's behalf with respect to this authorization form.

_____ _____

Patient or Authorized Representative Signature Date

ST. LOUIS FOOT AND ANKLE INSTITUTE

Authorization to Release Information to Other Parties

Many of our patients allow family members such as their spouse, significant other, parents, or children to call and request the result of tests, procedures, and financial information. Under the requirements for HIPAA, we are not allowed to give this information to anyone without the patient's consent. If you wish to have your medical information, any diagnostic test results and/or financial information released to any family members you must sign this form. You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

I authorize St. Louis Foot and Ankle Institute, LLC to release my records and any information requested to the following individuals.

1. _____ Relation to Patient: _____
2. _____ Relation to Patient: _____
3. _____ Relation to Patient: _____

Authorization Regarding Messages (please check all that apply)

- □ I authorize you to speak with the above individuals or leave a detailed message on my home or cell number regarding medical treatment, care, test results, billing or financial information.
- □ I authorize you to leave a message on my voicemail or with anyone who answers the phone.
- □ Messages may only be left with: _____

_____ _____

Patient or Authorized Representative Signature Date

ST. LOUIS FOOT AND ANKLE INSTITUTE

PATIENT INFORMATION

Patient Name: _____

Height: _____ Weight: _____ Shoe Size: _____

ALLERGIES

☐ NONE	☐ Erythromycin	☐ Sulfa Drugs	☐ Pollen
☐ Acetaminophen	☐ Ibuprofen/NSAIDS	☐ Tetracycline	☐ Milk
☐ Aspirin	☐ Lidocaine	☐ Lidocaine	☐ Eggs
☐ Cephalexin	☐ Morphine	☐ Cats	☐ _____
☐ Ciprofloxacin	☐ Penicillin	☐ Dogs	☐ _____
☐ Codeine	☐ Steroids	☐ Mold	☐ _____

MEDICATIONS – please list all prescriptions and OTC supplements

☐ **NONE**

Name: _____ Dose: _____ Frequency: _____

Name: _____ Dose: _____ Frequency: _____

Name: _____ Dose: _____ Frequency: _____

Name: _____ Dose: _____ Frequency: _____

Name: _____ Dose: _____ Frequency: _____

Name: _____ Dose: _____ Frequency: _____

Name: _____ Dose: _____ Frequency: _____

Name: _____ Dose: _____ Frequency: _____

Name: _____ Dose: _____ Frequency: _____

Name: _____ Dose: _____ Frequency: _____

Name: _____ Dose: _____ Frequency: _____

Name: _____ Dose: _____ Frequency: _____

Name: _____ Dose: _____ Frequency: _____

If you need more space, please ask for an additional form.

ST. LOUIS FOOT AND ANKLE INSTITUTE

FAMILY HISTORY – Specify relationship (mother, grandfather, sister, uncle, e.g., & person's age when the condition began/occurred.

☐ **No Family History**

☐ **I do not know my family history**

- ☐ Arthritis - _____
  - o Osteoarthritis
  - o Psoriatic
  - o Rheumatoid
- ☐ Blood Clots - _____
- ☐ Cancer
  - o Breast - _____
  - o Lung - _____
  - o _____
- ☐ Diabetes -_____
  - o Type 1
  - o Type 2
- ☐ COPD - _____
- ☐ Coronary Artery Disease - _____
- ☐ Deep Vein Thrombosis - _____
- ☐ Gout - _____
- ☐ Heart Disease - _____
- ☐ Heart Attack - _____
- ☐ High Blood Pressure - _____
- ☐ Pulmonary Embolism (PE) - _____
- ☐ Stroke - _____
- ☐ _____
- ☐ _____
- ☐ _____

If you or someone in your family has a medical condition that is not listed above, please write about it here:

_____

SOCIAL HISTORY

Do you have an Advanced Directive? □ Yes □ No
Do you have a medical Power of Attorney? □ Yes □ No

Tobacco Use

- ☐ No
- ☐ Yes
  - o Cigarettes
    - Packs per day □ ½ □ 1 □ 2 □ 3 □ 4
  - o Vape
    - o □ Daily (5-7 days/week) □ Weekly (1-3x week) □ Monthly (2-3x month)
  - o Cigars
    - o □ Daily (5-7 days/week) □ Weekly (1-3x week) □ Monthly (2-3x month)
  - o Dip/Chewing Tobacco
    - o □ Daily (5-7 days/week) □ Weekly (1-3x week) □ Monthly (2-3x month)
- ☐ Former Smoker
  - o Quit Date _____

Alcohol Consumption

- ☐ No
- ☐ Yes
  - o □ Daily (5-7 days/week) □ Weekly (1-3x week) □ Monthly (2-3x month)

Non-medical drug use

- ☐ No
- ☐ Yes - I currently use non prescribed drugs
- ☐ Yes - In the past I used non prescribed drugs.

Do you exercise?

- ☐ No, I do not.
- ☐ Yes, I do the following regular exercise: _____

ST. LOUIS FOOT AND ANKLE INSTITUTE

SURGICAL HISTORY

Have you ever had any surgical procedure on your foot/ankle? ☐ Yes ☐ No

If yes:

Procedure: _____ Surgeon: _____ Date: _____

Procedure: _____ Surgeon: _____ Date: _____

Procedure: _____ Surgeon: _____ Date: _____

- ☐ NONE
- ☐ Angioplasty
- ☐ Back Surgery
- ☐ Bunion
- ☐ Cosmetic Surgery
- ☐ C Section
- ☐ Colonoscopy
- ☐ Cataracts
- ☐ Gall Bladder
- ☐ Gastric Bypass
- ☐ Hammertoe
- ☐ Hernia
- ☐ Heart Surgery
- ☐ Hysterectomy
- ☐ Joint Replacement
  - Hip
  - Knee
  - _____
- ☐ Tonsils/Adenoids
- ☐ Wisdom Teeth
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____

MEDICAL HISTORY

- ☐ Allergies
- ☐ Anemia
- ☐ Anxiety
- ☐ Arthritis
  - Osteo
  - Psoriatic
  - Rheumatoid
- ☐ Asthma
- ☐ Back Pain
- ☐ Bleeding Disorder
- ☐ Blood Clots
- ☐ Cancer
  - _____
  - _____
- ☐ Circulation Problems
- ☐ COPD
- ☐ Coronary Artery Disease
- ☐ Deep Vein Thrombosis
- ☐ Depression
- ☐ Diabetes
  - Type 1
  - Type 2
- ☐ Edema
- ☐ Emphysema
- ☐ Fibromyalgia
- ☐ Gout
- ☐ Heart Disease
- ☐ Hepatitis – A B C
- ☐ High Cholesterol
- ☐ Hypertension
- ☐ HIV/AIDS
- ☐ Kidney Disease
- ☐ Leg/Foot Ulcer
- ☐ Liver Disease
- ☐ Lung Disease
- ☐ Lymphedema
- ☐ Metal Illness
  - _____
- ☐ Neuropathy
- ☐ Osteoporosis
- ☐ Pacemaker
- ☐ Pulmonary Embolism
- ☐ PVD
- ☐ Raynaud's
- ☐ Restless Leg
- ☐ Sleep Apnea
- ☐ Seizures
- ☐ Stroke
- ☐ Thyroid Disease
- ☐ Varicose Veins
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____

ST. LOUIS FOOT AND ANKLE INSTITUTE

Review of Systems (Please check the box if you *currently* are experiencing any of these symptoms

Constitutional
- ☐ Fever
- ☐ Chills
- ☐ Night Sweats
- ☐ Weight Gain _____ lbs.
- ☐ Weight Loss _____ lbs.
- ☐ Exercise Intolerance

Eyes
- ☐ Dry Eye
- ☐ Changes in Vision
- ☐ Eye Irritation
- ☐ Eye Drainage
- ☐ Wear glasses/contact lens

Ears
- ☐ Difficulty hearing
- ☐ Ear Pain
- ☐ Hearing Loss
- ☐ Ringing

Nose
- ☐ Nosebleeds
- ☐ Sinus problems
- ☐ Sinus Drainage
- ☐ Runny Nose

Endocrine
- ☐ Hair loss
- ☐ Fatigue
- ☐ Cold Intolerance

Mouth/Throat
- ☐ Sore throat
- ☐ Bleeding gums
- ☐ Dry mouth
- ☐ Mouth Ulcers
- ☐ Snoring
- ☐ Loose teeth

Cardiovascular
- ☐ Chest pain
- ☐ Arm pain with exertion
- ☐ Shortness of breath with activity
- ☐ Palpitations
- ☐ Heart murmur
- ☐ Leg Swelling

Respiratory
- ☐ Cough
- ☐ Wheezing
- ☐ Shortness of breath
- ☐ Coughing up blood
- ☐ Sleep Apnea

Gastrointestinal
- ☐ Abdominal Pain
- ☐ Nausea
- ☐ Vomiting
- ☐ Constipation
- ☐ Change in appetite
- ☐ GERD

Urinary
- ☐ Incontinence
- ☐ Difficulty urinating
- ☐ Increased frequency
- ☐ Blood in urine

Musculoskeletal
- ☐ Muscle aches
- ☐ Muscle weakness
- ☐ Back pain
- ☐ Joint pain
- ☐ Neck pain
- ☐ Muscle cramps

Integument/Skin
- ☐ Abnormal moles
- ☐ Rash
- ☐ Itching
- ☐ Dry Skin
- ☐ Slow healing cuts/wounds

Psychiatric
- ☐ Depression
- ☐ Anxiety
- ☐ Mood swings
- ☐ Memory issues

Hematologic/Lymphatic
- ☐ Easy bruising
- ☐ Swollen glands
- ☐ Excessive bleeding

ST. LOUIS FOOT AND ANKLE INSTITUTE

Reason for Visit

- ☐ New Problem
- ☐ Continued Problem
- ☐ Injury
- ☐ Second Opinion
- ☐ Referral for Surgery

When did symptoms/pain start? _____

What have you tried at home?

- ☐ NSAIDS
- ☐ Rest
- ☐ Ice
- ☐ Elevation
- ☐ Decreasing Activity
- ☐ Home Exercises/Stretches
- ☐ Changes in Shoes
- ☐ Shoe Inserts/Orthotics
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____

Have they been effective? ☐ Yes ☐ No

On a scale of 0 – 10 (0 being no pain and 10 being the worst pain you've ever had)
What is your current level of pain? _____

The pain is:

- ☐ Intermittent
- ☐ Constant
- ☐ Activity dependent
- ☐ Aching
- ☐ Throbbing
- ☐ Stabbing
- ☐ Burning
- ☐ Tingling
- ☐ Dull
- ☐ Sharp
- ☐ Shooting
- ☐ Numb

What makes the pain worse?

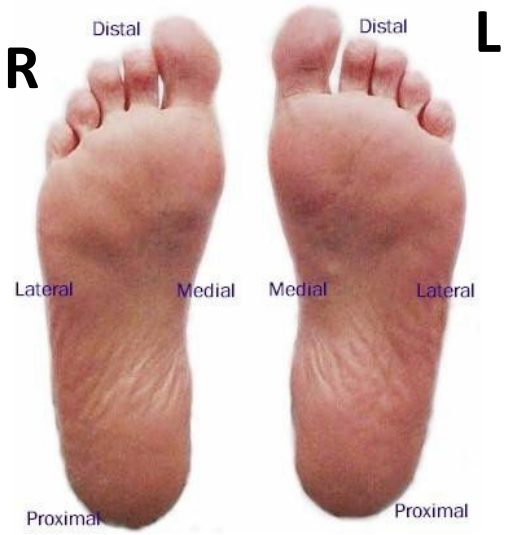
- ☐ Walking
- ☐ Standing
- ☐ Running
- ☐ All activity
- ☐ Shoes
- ☐ Working out
- ☐ Other _____

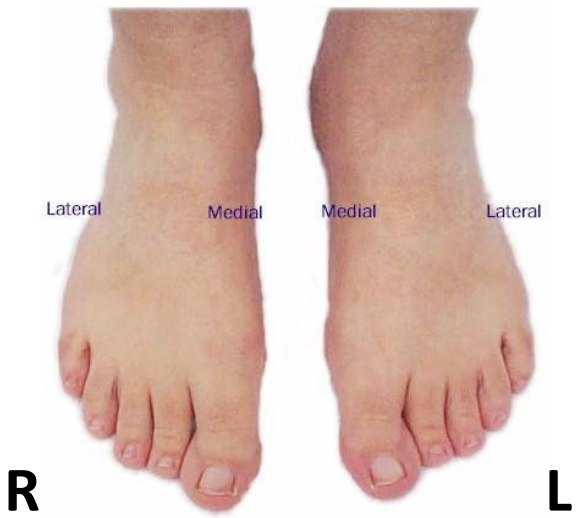
Is this condition the result of an injury at work? ☐ Yes ☐ No
Have notified your employer and the worker's compensation liaison at your employer? ☐ Yes ☐ No
What is their contact information? _____

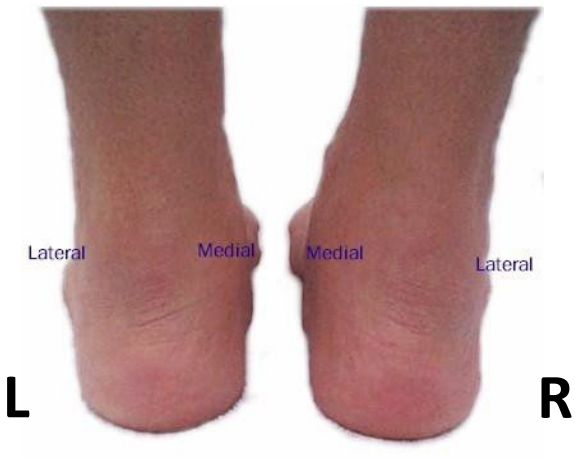
Is this condition a result of a motor vehicle accident? ☐ Yes ☐ No
Are you represented by an attorney? ☐ Yes ☐ No
What is their contact information? _____

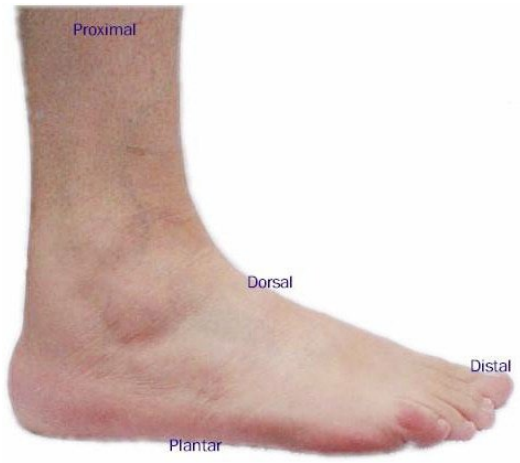
ST. LOUIS
FOOT AND ANKLE
INSTITUTE

Mark with an "X" where you are having pain.









****** Please note that the physician and staff of St. Louis Foot and Ankle Institute do not consent to audio or video recordings of any kind during evaluation, treatment, or procedures. We kindly ask that you silence your phone and refrain from usage during your exam and any treatments. ******

By signing below, I certify that I have read and understood all materials and that the above information is correct to the best of my knowledge. I understand that throughout my treatment, I am responsible for notifying the physician and/or medical staff or any and all updates to the information listed above.

_____ _____

Patient or Authorized Representative Signature Date