American College of Foot and Ankle Surgeons™

Proven leaders. Lifelong learners. Changing lives.

Patient Intake Form

Today's Date: *(Fecha)* _____

Reason for visit: _____ *(Razon de la visita)*

Referred by: _____ *(Referido por)*

PLEASE PRINT

PATIENT'S NAME (last, first) *(Nombre de el paciente)*									
ADDRESS, CITY, STATE, ZIP *(Direccion, Cuidad, Estado, Codigo postal)*									
AGE *(Edad)*	**DATE OF BIRTH** *(Fecha de nacimiento)*	**SEX** *(Sexo)*		**MARITAL STATUS** *(Estado Civil)*					**SOCIAL SECURITY #** *(Numbero de Seguro Social)*
		M	F	S	M *(C)*	W *(V)*	D	SEP	
HOME PHONE #: *(Numero de telefono)*		**CELLULAR PHONE #:** *(Celular)*						**WORK PHONE & EXT. APPLICABLE** *(Trabajo)*	
Employer's Name *(Nombre de su empleado)*				**Address & Title** *(Direccion)*					
In case of an emergency contact: *(Contacto de emergencia)*			**Telephone No.** *(Numero de telefono)*					**Relationship** *(Relacion)*	

INSURANCE INFORMATION: *(Informacion de Seguro)*

Is your injury a result of an accident? **NO YES** *(Es su herida resultado de un accidente?)* Date of accident: *(Fecha de accidente)* _____	If **yes**, please circle what type of accident you had: *(Que tipo de accidente?)* Motor vehicle *(Accidente de carro)* Worker's comp. *(Accidente de trabajo)* Slip & fall *(Caida)*
Primary Insurance Carrier: *(Seguro primario)*	Telephone No.: *(Numbero de telefono)*
I.D. / Claim No. *(Number de identificacion)*	Adjuster / Case Manager: *(Nombre de la persona encargada de su caso)*
Secondary Insurance Carrier: *(Seguro secundario)*	Telephone No.: *(Numbero de telefono)*
I.D. / Claim No. *(Number de identificacion)*	Group No.:
Tertiary Insurance Carrier:	Telephone No.:
I.D. / Claim No.	Group No.:

If you are being represented by an attorney, please supply us with their complete information:
(Si esta siendo representado por un abogado, porfavor escriba la informacion aqui)

Name: _____ Telephone No.: _____

Address, City, State & Zip: _____

PAGE 2: PLEASE PRINT ALL INFORMATION

Height: _____ **Weight:** _____
(Estatura) *(Peso)*

Do you smoke? NO YES (how much?) _____
(Usted fuma?) *(Cuanto)*

Do you consume alcohol? NO YES (how often?) _____
(Consume alcohol?) *(Frequencia)*

5 MEDICAL HISTORY

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

AIDS/HIV	☐ Yes	☐ No	Epilepsy	☐ Yes	☐ No	Rash	☐ Yes	☐ No
Allergies to Anesthetics	☐ Yes	☐ No	Eye Problems	☐ Yes	☐ No	Respiratory Disease	☐ Yes	☐ No
Allergies to Medicine or Drugs	☐ Yes	☐ No	Fainting	☐ Yes	☐ No	Rheumatic Fever	☐ Yes	☐ No
Anemia	☐ Yes	☐ No	Foot or Leg Cramps	☐ Yes	☐ No	Shortness of Breath	☐ Yes	☐ No
Angina	☐ Yes	☐ No	Gout	☐ Yes	☐ No	Sinus Problems	☐ Yes	☐ No
Arthritis	☐ Yes	☐ No	Headaches	☐ Yes	☐ No	Special Diet	☐ Yes	☐ No
Artificial Heart Valves or Joints	☐ Yes	☐ No	Heart Disease	☐ Yes	☐ No	Stroke	☐ Yes	☐ No
Asthma	☐ Yes	☐ No	Hemophilia	☐ Yes	☐ No	Swelling in Ankles, Feet	☐ Yes	☐ No
Back Problems	☐ Yes	☐ No	Hepatitis or Jaundice	☐ Yes	☐ No	Swollen Neck Glands	☐ Yes	☐ No
Bleeding Disorders	☐ Yes	☐ No	High Blood Pressure	☐ Yes	☐ No	Tired Feet	☐ Yes	☐ No
Cancer	☐ Yes	☐ No	Kidney Problems	☐ Yes	☐ No	Tuberculosis	☐ Yes	☐ No
Chemical Dependency	☐ Yes	☐ No	Liver Disease	☐ Yes	☐ No	Ulcers	☐ Yes	☐ No
Chest Pain	☐ Yes	☐ No	Low Blood Pressure	☐ Yes	☐ No	Varicose Veins	☐ Yes	☐ No
Chronic Diarrhea	☐ Yes	☐ No	Neuropathy	☐ Yes	☐ No	Venereal Disease	☐ Yes	☐ No
Circulatory Problems	☐ Yes	☐ No	Phlebitis	☐ Yes	☐ No	Weight Loss, unexplained	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No	Psychiatric Care	☐ Yes	☐ No			
Ear Problems	☐ Yes	☐ No	Radiation Treatment	☐ Yes	☐ No			

Surgeries you have had _____

_____

_____

Hospitalization other than for the surgeries listed _____

_____

_____

Family physician _____ Last visit date _____

Are you now, or have you been, under any other doctor's care for any reason over the past two years? ☐ Yes ☐ No

If yes, please explain _____

_____

_____

6 MEDICATIONS

Include prescriptions, over-the-counter medications and vitamins _____

_____

_____

Pharmacy Name(s) _____

Pharmacy Phone(s) (_____) _____

Do you take oral contraceptives? ☐ Yes ☐ No

7 ALLERGIES

☐ Adhesive/Tape	☐ Local Anesthetics
☐ Anticoagulant Therapy	☐ Novocaine
☐ Aspirin	☐ Penicillin
☐ Codeine	☐ Seafoods
☐ Demerol	☐ Sulfa
☐ Iodine	

Other _____

TREATMENT CONSENT

I hereby consent and give my permission to the doctor (and the doctor's assistants or designated replacement) to administer and perform such procedures upon me as the doctor deems necessary.

_____ _____
Signature of Patient, Parent, Guardian or Personal Representative — Date

_____ _____
Please print name of Patient, Parent, Guardian or Personal Representative — Relationship to Patient

CONSENTS:

Patient name:_____Date: _____

ASSIGNMENT OF BENEFITS AND INSURANCE AUTHORIZATION

I hereby authorize Robert W. Hutchison, DPM, LLC to furnish information to insurance carriers concerning my illness and treatments. I hereby assign all payments, for medical services rendered to myself or my dependent, to the physicians. I understand that I am responsible for any amount not covered by my insurance.

I am assigning all my rights unconditionally to Robert W. Hutchison, DPM, LLC to pursue any medical bills, relating to treatment or care by this office in addition to the above.

X_____
Patient signature

NO FAULT AND/OR WORKER'S COMPENSATION PATIENTS

I hereby authorize the release of my medical chart, bills and/or any other information related to my treatment, to my attorney_____.

I further authorize Robert W. Hutchison, DPM, LLC to pursue payment of my bills. I understand that all medical bills will be submitted to the responsible insurance carrier and will *only* be submitted to my medical insurance carrier in the event that payment is denied and/or there is a remaining balance, which I am responsible for. I understand that I am directly and fully responsible for all medical bills submitted by you for services rendered to myself or my dependent and that this agreement is made solely for your additional protection and in consideration of your awaiting payment. I further understand that your attorney, if needed will arbitrate my bills for payment.

X_____
Patient signature

HIPPA PRIVACY ACKNOWLEDGEMENT

I,_____, acknowledge that I have been provided with a copy of Robert W. Hutchison, DPM, LLC privacy notice.

This notice is effective as of today's date.
X_____
Patient Signature

PHOTOGRAPH CONSENT
I,_____, authorize my picture be taken. I understand that my photograph will be attached to my medical chart and only used for identification purposes. I understand & do not authorize my image be used for any other purpose.
X_____
Patient Signature
( ) Declined - You may opt not have your photograph taken but must supply us with picture identification for our records.

Robert W. Hutchison, DPM, FACFAS
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