Florida Foot & Ankle Care – Dr. Jonathan Selbst

Patient Information Today's Date: _____

First Name: _____ Last Name: _____Date of Birth: _____/_____/_____

Gender: ☐ M ☐ F Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced SS#:_____/_____/_____

Address: _____Unit: _____City:_____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Email: _____

How would you like to receive appointment reminders (check all): ☐ Phone ☐ Text ☐ Email Can we leave a VM: ☐ Yes ☐ No

Employer: _____ Phone: _____

Language: _____ ***Race***: ☐ Am Indian ☐ Asian ☐ Black/Afr-Am ☐ White ☐ Decline ***Ethnicity***: ☐ Hispanic/Latino ☐ Other ☐ Decline

Contact Information: In case of emergency who should we contact?

Name: _____Relationship: _____ Phone #: _____

Who can we leave a message with? ☐ Spouse ☐ Child ☐ Other: _____

Insurance

Primary Insurance: _____ Policy ID: _____

Subscriber Name:_____ DOB: _____ Relationship to insured: ☐ *self* ☐ *spouse* ☐ *child*

Secondary Insurance: _____ Policy ID: _____

Subscriber Name:_____ DOB: _____ Relationship to insured: ☐ *self* ☐ *spouse* ☐ *child*

Guarantor Information Who is responsible for payment on this account? ☐ *Same as patient*

Name:_____ Relationship:_____DOB:_____

Address:_____Phone #: _____

PCP: _____ **Phone**: _____ **Date Last Seen:** _____

Do you have a history of Diabetes? ☐ Yes ☐ No If yes, name of monitoring physician: _____Date last seen:_____

Pharmacy: _____City: _____ Phone: _____

How did you find our practice: ☐ Doctor ☐ Internet ☐ Family ☐ Friend ☐ Other:_____

Last Flu Shot Date: _____ Did you get the pneumococcal vaccine? ☐ Yes ☐ No

Have you fallen in the past 12 months? ☐ Yes ☐ No If yes, were you injured? ☐ Yes ☐ No

Advanced Directives: ☐ Living Will ☐ DNR (Do Not Resuscitate) ☐ Power of Attorney ☐ Healthcare Surrogate ☐ None

Note: The information on my intake forms are correct to the best of my knowledge. I understand that throughout my treatment, I am responsible for notifying the physician and/or medical staff of any and all updates to the information listed above.

Patient/Guardian Signature: _____ *Date:* _____

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Chief Complaint

What is the reason for your visit today? _____

Where is your pain/problem located? ☐Toe ☐Heel ☐Ankle ☐Ball of foot ☐Arch ☐Left ☐Right ☐Both Feet

Other: _____ How long have you had this complaint? _____

Did the problem result from a specific injury? ☐ No ☐ Yes, please describe: _____

Please rate your pain on a scale of 1-10 (*10 being the most painful*): 1 2 3 4 5 6 7 8 9 10

The symptoms are: ☐ Aching ☐ Bruising ☐ Burning ☐ Constant ☐ Dull ☐ Numbness ☐ Radiating/Traveling

☐ Sharp ☐ Stabbing ☐ Swelling ☐ Throbbing ☐ Tingling ☐ Other: _____

Does anything make your symptoms feel *better*? _____

Does anything make your symptoms feel *worse*? _____

Have you seen another physician for this problem? ☐ Yes ☐ No *Doctor's Name*: _____

What treatments have you tried? ☐ None ☐ Physical therapy ☐ Injections ☐ Insoles ☐ Bracing ☐ Icing ☐ Compression

☐ Medications ☐ Resting ☐ Shoe change ☐ Other: _____

Have you had any of the following tests/studies for this condition/complaint? ☐ X-rays ☐ Blood test ☐ MRI ☐ CT scan

If so, where were the tests performed? _____

Allergies ☐ No Known Allergies

Name:	Reaction:	Name:	Reaction:
Name:	Reaction:	Name:	Reaction:

Medications ☐ None

Name:	Dose:	Name:	Dose:
Name:	Dose:	Name:	Dose:
Name:	Dose:	Name:	Dose:
Name:	Dose:	Name:	Dose:
Name:	Dose:	Name:	Dose:
Name:	Dose:	Name:	Dose:
Name:	Dose:	Name:	Dose:

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Family History Is there any family history (blood relative) of any condition below? **Indicate below:** Living (**L**) or Deceased (**D**)

Family member: M = Mother / F = Father / S = Son / D = Daughter / GM = Grandmother / GF = Grandfather

	Family Member	L/D		Family Member	L/D		Family Member	L/D
☐ Alzheimer's			☐ Arthritis			☐ Bleeding Disorders		
☐ Blood Clot			☐ Cancer			☐ Cataracts		
☐ Circulation Problems			☐ Depression			☐ Diabetes		
☐ Heart Disease			☐ High Blood Pressure			☐ Neurological		
☐ Stroke			☐ Other					

Patient Medical History Do you have or have you ever been treated for any of the following conditions?

☐ Anxiety	☐ Arthritis	☐ Asthma	☐ Atrial Fibrillation	☐ Back Problems
☐ Bipolar Disorder	☐ Blood Clot	☐ Congestive Heart Failure	☐ Cancer (type):	
☐ COPD	☐ Depression	☐ Diabetes: Type: ____	☐ Enlarged Prostate	☐ Fibromyalgia
☐ GERD	☐ Headaches	☐ Heart Attack	☐ Heart-Disease	☐ Hepatitis
☐ High Blood Pressure	☐ High Cholesterol	☐ HIV/AIDS	☐ Kidney Disease: Stage: _____	☐ Liver Disease
☐ Multiple Sclerosis	☐ Neuropathy	☐ Osteoporosis	☐ Pacemaker	☐ Parkinson's Disease
☐ PTSD	☐ Psoriasis	☐ Raynaud's Disease	☐ Schizophrenia	☐ Seizure Disorder
☐ Sleep Apnea	☐ Stroke	☐ Thyroid Disease: hypo/hyper	☐ Ulcer of GI	☐ Vascular Disease
Other:				

Social History Do you smoke? ☐ No/Rarely ☐ Former ☐ Yes – # of years _____ # of packs per day _____

Do you drink alcohol? ☐ No ☐ Yes If yes, frequency: ☐ Socially ☐ Occasionally ☐ Light ☐ Heavy: 3+drinks/day

Do you exercise regularly: ☐ No ☐ Yes - Type and Frequency: _____

Surgical History ☐ **None**

☐ Angioplasty	☐Appendectomy	☐ Back Surgery	☐ Cataracts	☐ Cholecystectomy	☐ C-Section
☐ Fracture Repair	☐ Gallbladder	☐ Gastric Bypass	☐ Hernia repair	☐ Heart Bypass	☐ Heart Valve
☐ Hip Surgery – L / R	☐ Hysterectomy	☐ Knee Surgery L / R	☐ Leg Stents	☐ Pacemaker	☐ Spine Surgery
☐ Thyroidectomy	☐ Tonsillectomy	Other:			

Review of Systems: Please check the box if you currently have any of these symptoms or check "none."

Constitutional	☐ chills ☐ fatigue ☐ fever ☐ headache ☐ weakness ☐weight gain ☐ weight loss ☐ **NONE**
Head	☐ dizziness ☐ fainting ☐ headaches ☐ pain ☐ sweats ☐ **NONE**
Respiratory	☐ asthma ☐ bronchitis ☐ chest pain ☐ COPD ☐ cough ☐ shortness of breath ☐ wheezing ☐ **NONE**

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Cardiovascular	☐ chest pain ☐ cramps in legs/feet ☐ leg swelling ☐ cold feet ☐ hair loss on legs ☐ heart murmur ☐ leg pain when walking ☐ palpitations ☐ rheumatic fever ☐ varicose veins ☐ **NONE**
Gastrointestinal	☐ abdominal pain ☐ antiacid use ☐ constipation ☐ decreased appetite ☐ diarrhea ☐ difficulty swallowing ☐ diverticulitis ☐ excessive thirst ☐ GI or stomach ulcer ☐ heartburn ☐ hemorrhoids ☐ IBS ☐ nausea ☐ vomiting ☐ **NONE**
Musculoskeletal	☐ ankle pain ☐ arch pain ☐ arthritis ☐ back pain ☐ gait (walking) problems ☐ heel pain ☐ high arch ☐ imbalance ☐ joint pain ☐ joint stiffness ☐ joint swelling ☐ knee pain ☐ leg pain ☐ muscle cramps ☐ muscle stiffness ☐ neck pain ☐ sciatica ☐ toe pain ☐ toe swelling ☐ weakness ☐ **NONE**
Psychiatric	☐ anxiety ☐ depression ☐ disorientation ☐ forgetful ☐ irritable ☐ memory loss ☐ **NONE**
Skin	☐ skin scaling foot ☐ bleeding/drainage ☐ blister ☐ bruising ☐ callus ☐ discoloration of toe ☐ foot or leg ulcer ☐ itching ☐ mole change ☐ rash ☐ red toe ☐ skin lesion ☐ thickened nails ☐ wound on toe ☐ **NONE**
Neurological	☐ burning ☐ fainting ☐ neuropathy ☐ stroke ☐ tingling ☐ tremor ☐ unsteady gait ☐ vertigo ☐ **NONE**
Endocrine	☐ non-insulin dependent diabetes ☐ insulin dependent diabetes ☐ fatigue ☐ goiter ☐ sweats ☐ thirst ☐ thyroid ☐ weight gain ☐ weight loss ☐ **NONE**
Hematologic	☐ anemia ☐ bruising easily ☐ blood clots ☐ blood thinners ☐ clotting disorder ☐ recent chemotherapy ☐ slow healing cuts ☐ swollen glands ☐ **NONE**
Genitourinary	☐ blood in urine ☐ burning ☐ decreased urination ☐ excessive urination ☐ flank pain ☐ incontinence ☐ infections ☐ kidney stones ☐ retention ☐ urgency ☐ UTI ☐ **NONE**
Eye	☐ blurred vision ☐ cataracts ☐ contacts ☐ eyeglasses ☐ glaucoma ☐ macular degeneration ☐ **NONE**

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 medically necessary.

Patient/Guardian Signature: _____ Date: _____

Assignment of Benefits: I authorize payment of medical benefits to the practice named above. (Release of Information): I, the patient named below, do hereby authorize any physician examining and/or treating me to release to any third payer (such as insurance company or governmental agency) any medical, psychiatric condition, alcohol or drug related condition records concerning diagnosis and treatment when requested by such third party for its use in connection with determining a claim for payment.

Physician Insurance Assignment: I, the patient named below, hereby authorize payment directly to any physician examining or treating me or any group/individual surgical and/or medical benefits herein specified and otherwise payable to me for their services.

HIPAA Privacy: I acknowledge that I can view my HIPAA Privacy Practices Notice in the lobby and request a copy. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Private Practices.

Medication History: I authorize the medical office above to retrieve my medication history via e-prescribe, Surescripts or other third-party vendors.

Financial Policy: All health plans are not the same and do not cover the same services. In the event your health plan determines a service to be "not covered," or you do not have an authorization required, you will be responsible for the complete charge. We will attempt to verify and get referrals; however, you remain responsible for charges to any service rendered. You must inform the office of all insurance changes or you may be responsible for charges denied.

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