



ALOHA FOOT AND ANKLE ASSOCIATES, INC



Last Name _____ First Name _____ Middle Initial _____ Sex M F
 Address _____
 City _____ State _____ Zip _____ E-mail _____
 Cell phone () _____ Home Phone () _____ Work () _____
 Social Security # ___/___/___ Driver's Lic # _____ Age _____ Date of Birth ___/___/___
 Marital status _____ Children # _____ Ages _____
 Employer _____ City _____ State _____ Zip _____
 Occupation _____ May we call you at work Y N Work hours _____

For outstanding patient's balance should we contact you through?

Email _____
 Regular mail Fax _____ other _____

Financially Responsible Party (If different from patient)

Last Name _____ First Name _____ E-mail _____
 Address _____ City _____ State _____ Zip _____
 Date of Birth ___/___/___ Employer _____ Phone () _____ Ext _____

Insurance Information (Please bring insurance card to each appointment)

Type of Insurance PPO HMO POS EPO Medicare Self Pay Workers Comp
 Does your insurance require prior authorization? Yes No
 Who referred you? - _____ Phone: _____

INSURANCE INFORMATION PLEASE BRING INSURANCE CARD AND A PICTURE ID WE WILL MAKE COPIES FOR YOUR FILE

Please read and sign below: I directly assign all medical and surgical benefits to the doctors. I understand that I am financially responsible for all charges whether paid by my insurance provider or not. I authorize the doctor to release all information necessary to secure the payment of benefits. I understand that fees for service and insurance copays are payable at the time of service, unless other arrangements are made in advance. It is my responsibility to pay any deductible amount or co-insurance. It is the policy of this office to bill your insurance for reimbursement. However, we shall allow no more that sixty (60) days for payment. After sixty (60) days you will be billed for any outstanding balance on your account. All outstanding balances are due thirty (30) days from the statement date.
 I HEREBY GIVE AUTHORIZATION FOR TREATMENT. _____ Date _____



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PLEASE LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING (INCLUDE PRESCRIPTIONS, OVER-THE-COUNTER MEDS AND HERBAL SUPPLEMENTS):

NAME DOSE HOW OFTEN DO YOU TAKE?

PLEASE LIST ALL PRIOR SURGERIES AND SURGEON:

TYPE OF SURGERY DATE TYPE OF SURGERY DATE

PLEASE LIST ALL PRIOR HOSPITALIZATIONS (OTHER THAN FOR SURGERY):

REASON FOR HOSPITALIZATION DATE REASON FOR HOSPITALIZATION DATE

SOCIAL HISTORY

MARITAL STATUS: SINGLE MARRIED PARTNERED SEPARATED DIVORCED WIDOWED
USE OF ALCOHOL: NEVER NO LONGER USE HISTORY OF ALCOHOL ABUSE
CURRENT USE - TYPE RARE OCCASIONAL MODERATE DAILY
USE OF TOBACCO: NEVER QUIT - HOW LONG AGO? SMOKE PACKS/DAY FOR YEARS
USE OF RECREATIONAL DRUGS: NEVER QUIT - HOW LONG AGO? TYPE
CURRENT USE - TYPE RARE OCCASIONAL MODERATE DAILY
HOW MUCH ARE YOU ON YOUR FEET AT WORK? 10% 25% 50% 75% 100%
DO OTHERS DEPEND UPON YOU FOR THEIR CARE? CHILDREN-AGE(S) PET(S)-WHAT KIND?
ELDERLY OR DISABLED FAMILY MEMBER OTHER
EXERCISE: NEVER RARE OCCASIONAL WEEKLY SEVERAL TIMES A WEEK DAILY
TYPES OF EXERCISE:

FAMILY HISTORY

DO YOU HAVE A FAMILY HISTORY OF: DIABETES CANCER HEART DISEASE HIGH BLOOD PRESSURE
STROKE CORONARY ARTERY DISEASE THYROID DISEASE RHEUMATOID ARTHRITIS
OTHER

YOUR MEDICAL HISTORY

HEIGHT WEIGHT SHOE SIZE
ALLERGIES: NONE KNOWN MEDICATIONS
ANESTHESIA FOODS
TAPE LATEX SHELLFISH IODINE OTHER

SYSTEMS REVIEW

AS YOU REVIEW THE FOLLOWING LIST, PLEASE CHECK ANY OF THOSE PROBLEMS, WHICH AFFECT YOU

<p>CONSTITUTIONAL</p> <p><input type="checkbox"/> Recent weight gain Amount: _____</p> <p><input type="checkbox"/> Recent weight loss Amount: _____</p> <p><input type="checkbox"/> Fatigue</p> <p><input type="checkbox"/> Weakness</p> <p><input type="checkbox"/> Fever</p> <p style="text-align: center;">EYES</p> <p><input type="checkbox"/> Loss of vision</p> <p><input type="checkbox"/> Double or blurred vision</p> <p><input type="checkbox"/> Itching eyes</p> <p style="text-align: center;">EARS -NOSE-MOUTH-THROAT</p> <p><input type="checkbox"/> Bleeding in gums</p> <p><input type="checkbox"/> Ringing in ears</p> <p><input type="checkbox"/> Loss of Hearing</p> <p><input type="checkbox"/> Nosebleeds</p> <p><input type="checkbox"/> Runny nose</p> <p><input type="checkbox"/> Sore in mouth</p> <p><input type="checkbox"/> Loss of taste</p> <p><input type="checkbox"/> Dryness of mouth</p> <p><input type="checkbox"/> Frequent sore throats</p> <p><input type="checkbox"/> Difficulty in swallowing</p> <p style="text-align: center;">CARDIOVASCULAR</p> <p><input type="checkbox"/> Pain in chest</p> <p><input type="checkbox"/> Heart murmurs</p> <p><input type="checkbox"/> Irregular heart beat</p> <p><input type="checkbox"/> Sudden change in heart beat</p> <p><input type="checkbox"/> High blood pressure</p> <p style="text-align: center;">MUSCULOSKELETAL</p> <p><input type="checkbox"/> Morning stiffness Lasting how long? _____</p> <p><input type="checkbox"/> Joint pain</p> <p><input type="checkbox"/> Muscle weakness</p> <p><input type="checkbox"/> Muscle tenderness</p> <p><input type="checkbox"/> Joint swelling</p> <p><input type="checkbox"/> List joints affected in the last 6 months _____</p>	<p style="text-align: center;">GASTROINTESTINAL</p> <p><input type="checkbox"/> Nausea</p> <p><input type="checkbox"/> Vomiting of blood or coffee ground material</p> <p><input type="checkbox"/> Stomach pain relieved by food or milk</p> <p><input type="checkbox"/> Blood in stools</p> <p><input type="checkbox"/> Jaundice</p> <p><input type="checkbox"/> Persistent diarrhea</p> <p><input type="checkbox"/> Black stools</p> <p><input type="checkbox"/> Heartburn</p> <p><input type="checkbox"/> Increasing constipation</p> <p><input type="checkbox"/> Lactose Intolerance</p> <p><input type="checkbox"/> Change in appetite</p> <p><input type="checkbox"/> Other _____</p> <p style="text-align: center;">GENITOURINARY</p> <p><input type="checkbox"/> Difficult urination</p> <p><input type="checkbox"/> STD</p> <p><input type="checkbox"/> Pain or burning on urination</p> <p><input type="checkbox"/> Rash/ulcers</p> <p><input type="checkbox"/> Blood in urine</p> <p><input type="checkbox"/> Pus in urine</p> <p><input type="checkbox"/> Cloudy "smoky" urine</p> <p><input type="checkbox"/> Discharge from penis/vagina</p> <p><input type="checkbox"/> Getting up at night to pass urine</p> <p><input type="checkbox"/> Sexual difficulties</p> <p><input type="checkbox"/> Vaginal dryness</p> <p><input type="checkbox"/> Incontinence</p> <p><input type="checkbox"/> Other _____</p> <p style="text-align: center;">RESPIRATORY</p> <p><input type="checkbox"/> Shortness of breath</p> <p><input type="checkbox"/> Difficulty in breathing at night</p> <p><input type="checkbox"/> Wheezing (asthma)</p> <p><input type="checkbox"/> Swollen legs or feet</p> <p><input type="checkbox"/> Cough</p> <p><input type="checkbox"/> Coughing up blood</p>	<p style="text-align: center;">INTEGUMENTARY (SKIN)</p> <p><input type="checkbox"/> Easy bruising</p> <p><input type="checkbox"/> Redness</p> <p><input type="checkbox"/> Rash</p> <p><input type="checkbox"/> Hives</p> <p><input type="checkbox"/> Hair loss</p> <p><input type="checkbox"/> Tightness</p> <p><input type="checkbox"/> Nodules/bumps</p> <p><input type="checkbox"/> Color changes of hands or feet in the cold</p> <p style="text-align: center;">NEUROLOGICAL SYSTEM</p> <p><input type="checkbox"/> Paralysis</p> <p><input type="checkbox"/> Seizures</p> <p><input type="checkbox"/> Headaches</p> <p><input type="checkbox"/> Dizziness</p> <p><input type="checkbox"/> Night sweats</p> <p><input type="checkbox"/> Sensitivity or pain of hands an/or feet</p> <p><input type="checkbox"/> Memory loss</p> <p><input type="checkbox"/> Fainting</p> <p><input type="checkbox"/> Muscle spasm</p> <p><input type="checkbox"/> Loss of consciousness</p> <p style="text-align: center;">HEMATOLOGIC/LYMPHATIC</p> <p><input type="checkbox"/> Transfusion? When</p> <p><input type="checkbox"/> Swollen glands</p> <p><input type="checkbox"/> Bleeding tendency</p> <p><input type="checkbox"/> Tender glands</p> <p><input type="checkbox"/> Anemia</p> <p style="text-align: center;">PSYCHIATRIC</p> <p><input type="checkbox"/> Memory loss</p> <p><input type="checkbox"/> Anxiety</p> <p><input type="checkbox"/> Depression</p> <p><input type="checkbox"/> Difficulty falling asleep</p> <p><input type="checkbox"/> Difficulty staying asleep</p> <p style="text-align: center;">ENDOCRINE</p> <p><input type="checkbox"/> Excessive thirst</p> <p style="text-align: center;">ALLERGIC/IMMUNOLOGIC</p> <p><input type="checkbox"/> Frequent sneezing</p> <p><input type="checkbox"/> Increased susceptibility to infection</p>
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HAVE YOU EVER HAD ANY OF THE FOLLOWING?

ACID REFLUX	Y	N	FIBROMYALGIA	Y	N	NEUROPATHY	Y	N
ANEMIA	Y	N	GOUT	Y	N	OPEN SORES	Y	N
ARTHRITIS	Y	N	HEART ATTACK	Y	N	PNEUMONIA	Y	N
ASTHMA	Y	N	HEART DISEASE/FAILURE	Y	N	POLIO	Y	N
BACK TROUBLE	Y	N	HEPATITIS	Y	N	RHEUMATIC FEVER	Y	N
BLADDER INFECTIONS	Y	N	HIV+/AIDS	Y	N	SICKLE CELL DISEASE	Y	N
BLEEDING DISORDER	Y	N	HIGH BLOOD PRESSURE	Y	N	SKIN DISORDER	Y	N
BLOOD CLOTS	Y	N	KIDNEY DISEASE	Y	N	SLEEP APNEA	Y	N
BLOOD TRANSFUSION	Y	N	LIVER DISEASE	Y	N	STOMACH ULCERS	Y	N
BRONCHITIS/EMPHYSEMA	Y	N	LOW BLOOD PRESSURE	Y	N	STROKE	Y	N
CANCER	Y	N	MIGRAINE HEADACHES	Y	N	THYROID DISEASE	Y	N
DIABETES	Y	N	MRSA	Y	N	TUBERCULOSIS	Y	N

OTHER CONDITIONS:

DO YOU HAVE IMPLANTS? (CHECK THOSE THAT MAY APPLY) CARDIAC COSMETIC ORTHOPEDIC PACEMAKER
PLEASE EXPLAIN _____

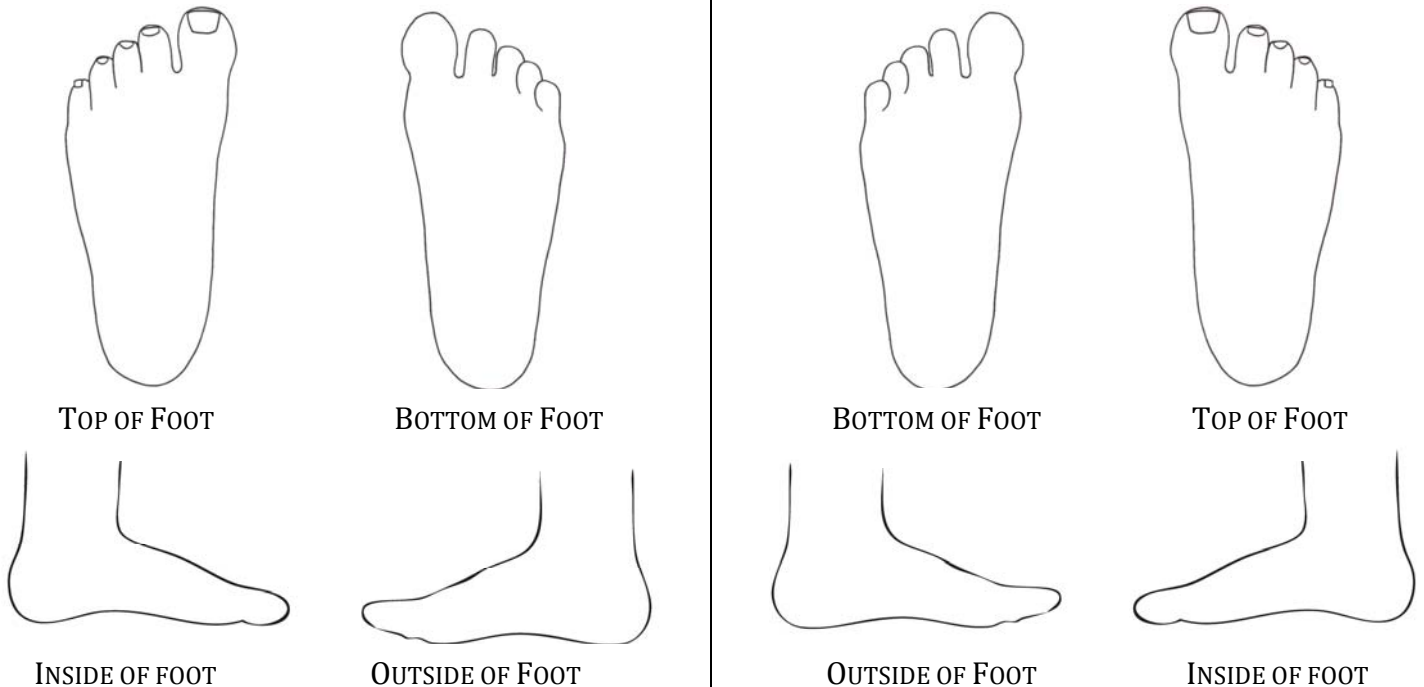
CURRENT PROBLEM

WHAT SPECIFIC PROBLEM BRINGS YOU TO OUR OFFICE TODAY?

WHERE IS THE PAIN/PROBLEM LOCATED? PLEASE MARK ON THE PICTURES BELOW.

LEFT FOOT

RIGHT FOOT



HOW LONG AGO DID THIS PROBLEM FIRST START? _____ DAYS / WEEKS / MONTHS / YEARS

DID YOUR PAIN OR PROBLEM: BEGIN ALL OF A SUDDEN GRADUALLY DEVELOPED OVER TIME

HOW WOULD YOU DESCRIBE YOUR PAIN? NO PAIN SHARP DULL ACHING BURNING
 RADIATING ITCHING STABBING OTHER _____

HOW WOULD YOU RATE YOUR PAIN ON A SCALE FROM 0 TO 10? (PLEASE CIRCLE)

(NO PAIN) 0 1 2 3 4 5 6 7 8 9 10 (WORST PAIN POSSIBLE)

SINCE THE TIME YOUR PAIN OR PROBLEM BEGAN, HAS IT: STAYED THE SAME BECOME WORSE IMPROVED

WHAT MAKES YOUR PAIN OR PROBLEM FEEL WORSE? WALKING STANDING DAILY ACTIVITIES
 RESTING DRESS SHOES HIGH HEELS FLAT SHOES ANY CLOSED TOE SHOE
 RUNNING OTHER _____

WHAT MAKES YOUR PAIN OR PROBLEM FEEL BETTER?

WHAT TREATMENTS HAVE YOU HAD FOR THIS PROBLEM?

HOW HAS THIS PROBLEM AFFECTED YOUR LIFESTYLE OR ABILITY TO WORK?

WAS THIS PROBLEM CAUSED BY AN INJURY? YES (DESCRIBE) _____ No

IF YES, WAS IT A WORK-RELATED INJURY? YES No DATE OF INJURY _____

TO THE BEST OF MY KNOWLEDGE, I HAVE ANSWERED THE QUESTIONS ON THIS FORM ACCURATELY. I UNDERSTAND THAT PROVIDING INCORRECT INFORMATION CAN BE DANGEROUS TO MY HEALTH. I UNDERSTAND THAT IT IS MY RESPONSIBILITY TO INFORM THE DOCTOR AND OFFICE STAFF OF, ALOHA FOOT AND ANKLE ASSOCIATES INC., ANY CHANGES IN MY MEDICAL STATUS.

PRINT NAME OF PATIENT, PARENT OR GUARDIAN

SIGNATURE OF DOCTOR

IF OTHER THAN PATIENT, RELATIONSHIP TO PATIENT

DATE

SIGNATURE

DATE



Notice of Privacy Practices & Acknowledgment and Consent

The Health Insurance Portability & Accountability Act of 1996("HIPPA") requires that all medical records and other individually identifiable health information is used or disclosed by this organization be kept properly confidential. The patient has the right to understand and control how their health information is used or disclosed. Any misuse of personal health information is subject to penalties. Please read the following ...

We may use and disclose patient medical records for the purpose of treatment or payment for the individual listed below.

We may contact patients for appointment reminders or any other health care information; however, any other uses and disclosures may be made only with the patient's written or verbal consent or authorization.

Patients have the following rights with respect to their health information. Patients may exercise these rights by submitting a written request to the address indicated above, attention Privacy Officer.

-The right to request restriction on certain uses and disclosures of protected health information, including those related to family members, other relatives, close personal friends, or any other person identified by the patient. We are not required to agree to a requested restriction; however, if we do, we must abide by it unless patient agrees in writing to remove it.

-The right reasonable requests to receive confidential communications of protected health information from this organization by alternative means or locations.

-The right to inspect and copy protected health information.

-The right to amend protected health information.

-The right to receive an accounting of disclosures of protected health information.

-The right to request a copy of this notice.

We have the right to change our Privacy Practices from time to time, patients may request a current copy by writing to the address indicated above.

I hereby acknowledge that I have been given the right to review this organization's Privacy Practices and give my consent to use my protected information under the conditions provided.

Print Patient's Name

Print (Guardian) Signature

DATE