LEPOW FOOT & ANKLE SPECIALISTS

WELCOME TO OUR OFFICE

Date: ____/____/____

Who referred you to our office? ________________________________ PCP: ____________________________

Name: ____
Last First Middle

Address: __________________________________ City: _______________ State: ________ Zip: _______________

Phone: __________________________ Cell: ______________________ SSN: ____________________________

Birth Date: ____________________ Age: ______ Race: _______________ Email: _________________________

Single: _________ Married: ________ Divorced: ________ Widow: ________ Female: ________ Male: ________

Employer: _________________________________ Occupation: ______________________________________

Address: ____ Phone: ___________________________

Emergency Contact: ____________________ Relation: ____________________ Phone: ____________________

INSURANCE INFORMATION:

Insured Name: _______________________________ Relation: __________________ D.O.B. _________________

Insured SSN: ________________________________ Insured Employer: _______________________________

Employer Address: _________________________________ Work #: _______________ Phone: _______________

Do you have? HMO_____PPO_____Medicare_____Medicare HMO_____Medicaid HMO____Work Comp_____

If you fail to identify yourself as an HMO subscriber, you will be responsible for all charges incurred.
HMO subscribers must have a referral from their PCP.

Signature: ____ Date: _____/_____/_____

INSURANCE COVERAGE: *Insurance card must be presented and copied at the time of service.*

Primary Insurance:
Ins. Name: _______________________________
Insured: _________________________________
Group #: _________________________________

Secondary Insurance:
Ins. Name: _______________________________
Insured: _________________________________
Croup #: _________________________________

WORKMAN COMPENSATION INFORMATION:

Date of Injury: _____________ Employer Name:______________________ Address: ______________________

Name of Ins.: ____ Phone:___________________________

Contact Person: ______________________________________ Phone:___________________________

AUTHORIZATION OF BENEFITS TO PROVIDER: I hereby assign and relinquish my interest in and title to my insurance benefits to the physician/supplier listed above for medical services rendered. I understand that I am financially responsible for all charges whether or not covered by insurance.

Signature: ____ Date: _____/_____/_____

Lepow Foot & Ankle Specialists maintain investment relations with Kirby Glenn Surgical Center and College Park Pharmacy. The physicians may receive a return on their investment.

Signature: ____ Date: _____/_____/_____

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize the physician/supplier indicated above to furnish information to insurance carriers concerning this illness/accident. I realize that my records may be electronically transmitted and through some default may not be received by the intended recipient. Should this occur, I release the physician/supplier from all liability.

Signature: ____ Date: _____/_____/_____

CONSENT FOR TREATMENT: I consent for medical services and treatment from the physicians and staff of Lepow Foot & Ankle Specialists.

Signature: ____ Date _____/_____/_____

LEPOW FOOT & ANKLE SPECIALISTS
Patient History

Patient Name ____ Date _____/_____/________
Family Physician _____________________________________ Date of last visit __________
Chief Complaint ____

History of Present Illness. Briefly answer the following questions:
Any previous treatment for this problem? Yes _____ No _____ If yes, what was done.
____
____

When did your problem begin? ____
Locate the area of the problem ____
Describe any pain and/or disability ____
Is the pain: Burning ___ Throbbing ___ Sharp ___ Dull ___ Aching ___ Other ___
What causes the problem or makes it worse? _______________________________________
Was it caused by an injury? No _____ Yes _____ (explain) ___________________________
____

Are you taking any of the following:
Aspirin _____ Coumadin _____ Plavix _____

Personal History:
List any serious injuries and approximate age of occurrence ___________________________
____
Allergies: ☐ No known allergies. List any allergies and type of reaction __________________
____
Major Illnesses: List serious illnesses and approximate age ___________________________
____
Surgeries or Hospitalizations List any and approximate age __________________________
____

Family History: Is there a family history of any of these disorders:
☐ Tuberculosis ☐ Heart Attack ☐ Cancer ☐ Migraines ☐ Epilepsy
☐ Kidney Disease ☐ Spinal Disorder ☐ Diabetes ☐ Mental Illness ☐ Hypertension
☐ Allergies ☐ Arthritis ☐ T.B. ☐ Other _____________________

Social History:
Parents living: Yes ___ No ___ No. Sibilings ____ No. Children ____ No. Pregnancies _____
Use of Tobacco _____ Alcohol _____ Drugs _____

Review of Systems: **Patient Name** ________________

☐ Numbness	☐ Loss of feeling	☐ Paralysis	☐ Dizziness	☐ Fainting
☐ Headaches	☐ Muscle jerking	☐ Convulsions	☐ Forgetfulness	☐ Confusion
☐ Spine disease	☐ Depression	☐ Weakness	☐ Seizure	☐ Brain disease
☐ Stroke	☐ Other ____			

Cardiovascular:

☐ Chest pain	☐ Pain over heart	☐ Heart problem	☐ Weakness	☐ Leg pain walking
☐ Tiredness	☐ Heart attack	☐ Varicose veins	☐ Feet swell	☐ High blood pressure
☐ Hand swell	☐ Rapid heart beat	☐ Night sweats	☐ Other _______________________	

Skin:

☐ Psoriasis	☐ Itching	☐ Bruises	☐ Skin rash	☐ Abrasions
☐ Ulcerations	☐ Moles	☐ Discoloration	☐ Skin cancer	☐ Eczema
☐ Deformed nails	☐ Birth marks	☐ Hives	☐ Other _________________________	

Muscular Skeleton:

☐ Arthritis	☐ Stiffness	☐ Club foot	☐ Fractures	☐ Joint disease
☐ Bursitis	☐ Sprains	☐ Muscle pain	☐ Lumbago	☐ Sciatica
☐ Other ______________________________________				

Allergies:

☐ Penicillin	☐ Morphine	☐ Adhesive tape	☐ Foods	☐ Sulfa drugs
☐ Aspirin	☐ Codeine	☐ Any chemicals	☐ Other _____________________	

Blood Disorders:

☐ Anemia	☐ Jaundice	☐ Bleeding disorder

MEDICATION SHEET

Pharmacy Name ____

Pharmacy Phone No. ____________________________________

Name of Medication	Mg/Strength	Dosage