



A Medical Group, Inc.

PATIENT INFORMATION RECORD

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Today's Date _____

Chart Number _____

PATIENT		E-mail:			
Patient Legal Name (Last, First, Middle)		Date of Birth	Sex	Social Security No	Home Phone
Stree Address		City, State		Zip Code	Cell Phone
Can confidential messages be left on your answering machine or voicemail? <input type="checkbox"/> Yes <input type="checkbox"/> No		Drivers License Number		Marital Status	Your Work Phone
Patients Employer		Employer Address, City, State, Zip			Employers Phone
Spouse's Name (Last, First, Middle) <input type="checkbox"/> Not Applicable		Spouse's Date of Birth	Sex	Spouse's Social Security No	Spouse's Cell Phone
Spouse's Employer		Spouse's Employer Address, City, State, Zip			Spouse's Work Phone
Have we ever treated any members of your family?					

IF THE PATIENT IS A MINOR		Not Applicable <input type="checkbox"/>			
Mother's Name		Address, City, State, Zip			Mother's Home Phone
Mother's Employer		Busniess Phone Number		Mother's Social Security	
Mother's Employer's Address, City, State, Zip					
Father's Name		Address, City, State, Zip			Father's Home Phone
Father's Employer		Busniess Phone Number		Father's Social Security	
Father's Employer's Address, City, State, Zip					

INSURANCE INFORMATION	
PRIMARY INSURANCE	SECONDARY INSURANCE
Medicare <input type="checkbox"/> NA <input type="checkbox"/> Medicare or Medicaid Number	Medicare <input type="checkbox"/> NA <input type="checkbox"/> Medicare or Medicaid Number
Medicaid <input type="checkbox"/> NA <input type="checkbox"/>	Medicaid <input type="checkbox"/> NA <input type="checkbox"/>
InsuranceName	InsuranceName
Address	Address
City, State, Zip	City, State, Zip
Phone	Phone
ID Number	ID Number
Group Number	Group Number
Insured Name	Insured Name
Insured Date of Birth	Insured Date of Birth

INJURY Date: _____ **Not Applicable**

Location at time of injury:

Home Work Auto Other (describe)

PROVIDER'S FINANCIAL POLICY

Please note that payment in full is required at the time of service. For your convenience, we accept personal checks, Visa, Master Charge or American Express, as well as cash. Any insurance coverage that you may have is intended to protect you against financial loss and not as payment in full for your care.. Payment in full for your care is your responsibility and may not be postponed until the time your insurance reimburses you. This agreement will remain in effect until revoked by (the patient) (or provider?) in writing. A photocopy of this document is to be considered as valid as the original.

PATIENT'S INSURANCE AUTHORIZATION

I hereby authorize the processing of the listed medical insurance, either electronically or manually, by the listed facility. My signature authorizes payment of all major medical and/or surgical benefits to which I am entitled from the listed insurer to be paid to the listed provider assignee. I further authorize assignee to release all medical and/or insurance claim information necessary to secure the payment(s). I recognize my financial obligation for any co-insurance or deductible and non-covered services that may be required. This agreement will remain in effect until revoked by me in writing. A photocopy of this document is to be considered as valid as the original.

PATIENT'S TREATMENT AUTHORIZATION

I authorize treatment by **Balance Orthopaedic Foot and Ankle Care**. I have read the above paragraph regarding payment of fees, and I understand that I am solely responsible for all the charges incurred, regardless of insurance coverage or liability of another party. I will make sure that my claims are paid promptly.

Patient's Name (Please Print)

Signature of Patient/Guardian

Date

TREATMENT OF MINOR

I authorize Balance Orthopaedic Foot and Ankle Care to treat a minor named below.

Minor's Name

Signature of Parent / Guardian

Date

Dear Patient,

We are pleased that you have selected our office for your orthopaedic foot and ankle care.

Please fill out the enclosed forms completely, marking the “NONE” boxes where appropriate and listing where indicated the approximate dates of previous foot and ankle services, treatments, and evaluations. If you have had more than five examiners, please ask our staff for a supplementary page.

The forms are detailed but allow us to have information that helps to provide comprehensive medical or surgical care for your foot and ankle.

Please bring with you all X-RAYS, CT AND BONE SCAN STUDIES, AND MRI FILMS AND REPORTS that you have had done in regard to your foot or ankle problem.

Thank you for your assistance. We look forward to meeting you.

Sincerely,

Ronald W. Smith, M.D.

FOOT AND ANKLE HISTORY

Last _____ First _____ M.I. ____ Age ____ Today's Date _____

I have brought in x-rays or other images today: Yes No
 Source of x-rays/images (office or hospital name) _____

Occupation _____ Duration _____
 If retired, type of work? _____

REFERRING PARTY: (Please give name)

Physician _____ Phone _____ Fax _____
 Address _____ E-Mail _____
 City _____ State _____ ZIP _____
 Friend _____ Family Member _____
 Insurance Company _____ Attorney _____
 Other _____

PERSONAL PHYSICIAN (Same as referring physician)

Name _____ Phone _____ Fax _____
 Address _____ E-Mail _____
 City _____ State _____ ZIP _____
 Date of last visit _____

PRESENT GOAL IN SEEKING EVALUATION: Check one or more.

Relief of pain Correction of deformity Improvement of appearance
 Second opinion Other _____

MAIN PROBLEM: Check one or more.

Pain or aching Swelling Weakness Stiffness Deformity Lump
 Instability or giving out Other _____

LOCATION & DURATION OF MAIN PROBLEM: Check one or more. (indicate # of weeks, months, years)

Problem:	Duration Of Symptoms			Or Date Of Onset		
Leg	R <input type="checkbox"/>	L <input type="checkbox"/>	# __ weeks	# __ months	# __ years	_____
Ankle	R <input type="checkbox"/>	L <input type="checkbox"/>	# __ weeks	# __ months	# __ years	_____
Heel	R <input type="checkbox"/>	L <input type="checkbox"/>	# __ weeks	# __ months	# __ years	_____
Bunion	R <input type="checkbox"/>	L <input type="checkbox"/>	# __ weeks	# __ months	# __ years	_____
Top of arch	R <input type="checkbox"/>	L <input type="checkbox"/>	# __ weeks	# __ months	# __ years	_____
Sole of arch	R <input type="checkbox"/>	L <input type="checkbox"/>	# __ weeks	# __ months	# __ years	_____
Side of the foot	R <input type="checkbox"/>	L <input type="checkbox"/>	# __ weeks	# __ months	# __ years	_____
Ball of foot	R <input type="checkbox"/>	L <input type="checkbox"/>	# __ weeks	# __ months	# __ years	_____
Great toe	R <input type="checkbox"/>	L <input type="checkbox"/>	# __ weeks	# __ months	# __ years	_____
2nd toe	R <input type="checkbox"/>	L <input type="checkbox"/>	# __ weeks	# __ months	# __ years	_____
3rd toe	R <input type="checkbox"/>	L <input type="checkbox"/>	# __ weeks	# __ months	# __ years	_____
4th toe	R <input type="checkbox"/>	L <input type="checkbox"/>	# __ weeks	# __ months	# __ years	_____
5th toe	R <input type="checkbox"/>	L <input type="checkbox"/>	# __ weeks	# __ months	# __ years	_____

DESCRIPTION OF ONSET: Check one or more.

Congenital -- Crush Repetitive use -- Sudden onset --- Work-related ----
 Fall ----- Twist - Direct blow ----- Gradual onset --- Sports-related --
 No Injury ---- Other _____

BRIEFLY DRAW LOCATION OF MAIN PROBLEMS ON THE DIAGRAM ON THE NEXT PAGE.

Patient's Name _____

Chart No. _____

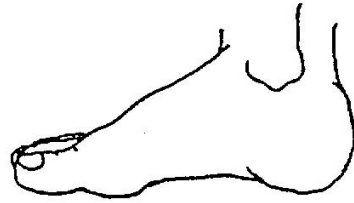
Date _____

CIRCLE AREA OF SYMPTOMS (label pain, swelling, weakness, stiffness, numbness, lumps, etc.)

RIGHT

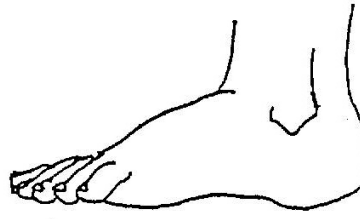


Lateral
(Outside)

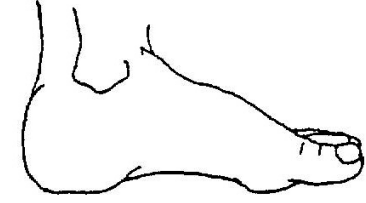


Medial
(Inside)

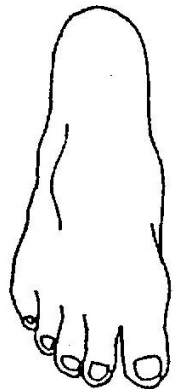
LEFT



Lateral
(Outside)

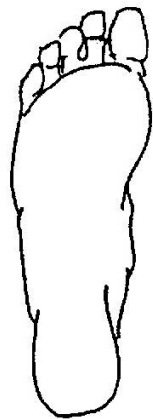


Medial
(Inside)



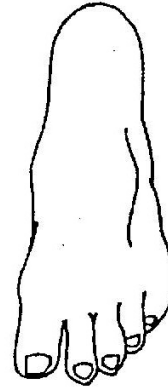
Dorsal
(Top)

RIGHT



Plantar
(Bottom)

LEFT



Dorsal
(Top)



Plantar
(Bottom)

FOOT AND ANKLE HISTORY

Briefly describe what happened when symptoms started, **and specify your location** at onset (home, work, etc.)

PREVIOUS TREATMENT OR EVALUATIONS: NONE (If none, skip to SELF CARE)

The **FIRST** doctor/E.R./Urgent Care I saw for this problem:

Name _____ City _____
 This doctor is a: Emergency Room Doctor Podiatrist Company doctor
 Family doctor Orthopedic surgeon Other _____
Date of first exam _____ **Date of last visit** _____ **# of visits** _____
 Tests: X-Rays Blood Tests Nerve Tests CT scan Bone Scan MRI

TREATMENT:

Steroid injections -----	<input type="checkbox"/>	How many _____	Date of last one _____	Helped? Yes <input type="checkbox"/>	No <input type="checkbox"/>
Anti-inflammatory pills--	<input type="checkbox"/>	Drug names _____		Helped? Yes <input type="checkbox"/>	No <input type="checkbox"/>
Pain pills-----	<input type="checkbox"/>	Drug names _____		Helped? Yes <input type="checkbox"/>	No <input type="checkbox"/>
Physical therapy-----	<input type="checkbox"/>	Number of visits _____		Helped? Yes <input type="checkbox"/>	No <input type="checkbox"/>
Pads/shoe modification	<input type="checkbox"/>	Type _____		Helped? Yes <input type="checkbox"/>	No <input type="checkbox"/>
Orthotics-----	<input type="checkbox"/>	Type _____		Helped? Yes <input type="checkbox"/>	No <input type="checkbox"/>
Cast <input type="checkbox"/> or Walker Boot	<input type="checkbox"/>	How long? _____		Helped? Yes <input type="checkbox"/>	No <input type="checkbox"/>
Surgery performed-----	<input type="checkbox"/>	Recommended surgery, did not do <input type="checkbox"/>		Helped? Yes <input type="checkbox"/>	No <input type="checkbox"/>
Other _____				Helped? Yes <input type="checkbox"/>	No <input type="checkbox"/>

The **SECOND** doctor I saw for this problem:

Name _____ City _____
 This doctor is a: Emergency Room Doctor Podiatrist Company doctor
 Family doctor Orthopedic surgeon Other _____
Date of first exam _____ **Date of last visit** _____ **# of visits** _____
 Tests: X-Rays Blood Tests Nerve Tests CT scan Bone Scan MRI

TREATMENT:

Steroid injections -----	<input type="checkbox"/>	How many _____	Date of last one _____	Helped? Yes <input type="checkbox"/>	No <input type="checkbox"/>
Anti-inflammatory pills--	<input type="checkbox"/>	Drug names _____		Helped? Yes <input type="checkbox"/>	No <input type="checkbox"/>
Pain pills-----	<input type="checkbox"/>	Drug names _____		Helped? Yes <input type="checkbox"/>	No <input type="checkbox"/>
Physical therapy-----	<input type="checkbox"/>	Number of visits _____		Helped? Yes <input type="checkbox"/>	No <input type="checkbox"/>
Pads/shoe modification	<input type="checkbox"/>	Type _____		Helped? Yes <input type="checkbox"/>	No <input type="checkbox"/>
Orthotics-----	<input type="checkbox"/>	Type _____		Helped? Yes <input type="checkbox"/>	No <input type="checkbox"/>
Cast <input type="checkbox"/> or Walker Boot	<input type="checkbox"/>	How long? _____		Helped? Yes <input type="checkbox"/>	No <input type="checkbox"/>
Surgery performed-----	<input type="checkbox"/>	Recommended surgery, did not do <input type="checkbox"/>		Helped? Yes <input type="checkbox"/>	No <input type="checkbox"/>
Other _____				Helped? Yes <input type="checkbox"/>	No <input type="checkbox"/>

FOOT AND ANKLE HISTORY

The **THIRD** doctor I saw for this problem:

Name _____ City _____
 This doctor is a: Emergency Room Doctor Podiatrist Company doctor
 Family doctor Orthopedic surgeon Other _____
Date of first exam _____ **Date of last visit** _____ **# of visits** _____
 Tests: X-Rays Blood Tests Nerve Tests CT scan Bone Scan MRI

TREATMENT:

Steroid injections -----	<input type="checkbox"/>	How many _____	Date of last one _____	Helped? Yes <input type="checkbox"/>	No <input type="checkbox"/>
Anti-inflammatory pills--	<input type="checkbox"/>	Drug names _____		Helped? Yes <input type="checkbox"/>	No <input type="checkbox"/>
Pain pills-----	<input type="checkbox"/>	Drug names _____		Helped? Yes <input type="checkbox"/>	No <input type="checkbox"/>
Physical therapy-----	<input type="checkbox"/>	Number of visits _____		Helped? Yes <input type="checkbox"/>	No <input type="checkbox"/>
Pads/shoe modification	<input type="checkbox"/>	Type _____		Helped? Yes <input type="checkbox"/>	No <input type="checkbox"/>
Orthotics-----	<input type="checkbox"/>	Type _____		Helped? Yes <input type="checkbox"/>	No <input type="checkbox"/>
Cast <input type="checkbox"/> or Walker Boot	<input type="checkbox"/>	How long? _____		Helped? Yes <input type="checkbox"/>	No <input type="checkbox"/>
Surgery performed-----	<input type="checkbox"/>	Recommended surgery, did not do <input type="checkbox"/>		Helped? Yes <input type="checkbox"/>	No <input type="checkbox"/>
Other _____				Helped? Yes <input type="checkbox"/>	No <input type="checkbox"/>

The **FOURTH** doctor I saw for this problem:

Name _____ City _____
 This doctor is a: Emergency Room Doctor Podiatrist Company doctor
 Family doctor Orthopedic surgeon Other _____
Date of first exam _____ **Date of last visit** _____ **# of visits** _____
 Tests: X-Rays Blood Tests Nerve Tests CT scan Bone Scan MRI

TREATMENT:

Steroid injections -----	<input type="checkbox"/>	How many _____	Date of last one _____	Helped? Yes <input type="checkbox"/>	No <input type="checkbox"/>
Anti-inflammatory pills--	<input type="checkbox"/>	Drug names _____		Helped? Yes <input type="checkbox"/>	No <input type="checkbox"/>
Pain pills-----	<input type="checkbox"/>	Drug names _____		Helped? Yes <input type="checkbox"/>	No <input type="checkbox"/>
Physical therapy-----	<input type="checkbox"/>	Number of visits _____		Helped? Yes <input type="checkbox"/>	No <input type="checkbox"/>
Pads/shoe modification	<input type="checkbox"/>	Type _____		Helped? Yes <input type="checkbox"/>	No <input type="checkbox"/>
Orthotics-----	<input type="checkbox"/>	Type _____		Helped? Yes <input type="checkbox"/>	No <input type="checkbox"/>
Cast <input type="checkbox"/> or Walker Boot	<input type="checkbox"/>	How long? _____		Helped? Yes <input type="checkbox"/>	No <input type="checkbox"/>
Surgery performed-----	<input type="checkbox"/>	Recommended surgery, did not do <input type="checkbox"/>		Helped? Yes <input type="checkbox"/>	No <input type="checkbox"/>
Other _____				Helped? Yes <input type="checkbox"/>	No <input type="checkbox"/>

The **FIFTH** doctor I saw for this problem:

Name _____ City _____
 This doctor is a: Emergency Room Doctor Podiatrist Company doctor
 Family doctor Orthopedic surgeon Other _____
Date of first exam _____ **Date of last visit** _____ **# of visits** _____
 Tests: X-Rays Blood Tests Nerve Tests CT scan Bone Scan MRI

TREATMENT:

Steroid injections -----	<input type="checkbox"/>	How many _____	Date of last one _____	Helped? Yes <input type="checkbox"/>	No <input type="checkbox"/>
Anti-inflammatory pills--	<input type="checkbox"/>	Drug names _____		Helped? Yes <input type="checkbox"/>	No <input type="checkbox"/>
Pain pills-----	<input type="checkbox"/>	Drug names _____		Helped? Yes <input type="checkbox"/>	No <input type="checkbox"/>
Physical therapy-----	<input type="checkbox"/>	Number of visits _____		Helped? Yes <input type="checkbox"/>	No <input type="checkbox"/>
Pads/shoe modification	<input type="checkbox"/>	Type _____		Helped? Yes <input type="checkbox"/>	No <input type="checkbox"/>
Orthotics-----	<input type="checkbox"/>	Type _____		Helped? Yes <input type="checkbox"/>	No <input type="checkbox"/>
Cast <input type="checkbox"/> or Walker Boot	<input type="checkbox"/>	How long? _____		Helped? Yes <input type="checkbox"/>	No <input type="checkbox"/>
Surgery performed-----	<input type="checkbox"/>	Recommended surgery, did not do <input type="checkbox"/>		Helped? Yes <input type="checkbox"/>	No <input type="checkbox"/>
Other _____				Helped? Yes <input type="checkbox"/>	No <input type="checkbox"/>

FOOT AND ANKLE HISTORY

FOOT AND ANKLE SURGERY: list earliest surgery first NONE
(Include foot surgeries **not** related to present problem)

1. Date _____ Doctor _____ Hospital _____
Type of surgery _____ Right _____ Left _____
Helped? Yes No Complications? (list) _____
Other _____
2. Date _____ Doctor _____ Hospital _____
Type of surgery _____ Right _____ Left _____
Helped? Yes No Complications? (list) _____
Other _____
3. Date _____ Doctor _____ Hospital _____
Type of surgery _____ Right _____ Left _____
Helped? Yes No Complications? (list) _____
Other _____

SELF CARE: None Other _____
Changed shoes Trimmed calluses Store bought pads or arch supports

ANTICIPATED SURGERY:
Would consider surgery if the doctor thinks it's necessary? Yes No

Generally, over time, I'm: Better Same Worse
Sports (if applicable): Current Sport _____ Position _____
Level (highschool, club, etc.) _____ Team _____ Coach _____

OTHER BODY AREAS AFFECTED BY MY FOOT/ANKLE INJURY/PROBLEM: None

How Related

- Head----- _____
- Neck ----- _____
- Low Back----- _____
- Shoulders----- R L _____
- Hips ----- R L _____
- Knees ----- R L _____

PREVIOUS INJURIES RELATED TO THIS PROBLEM: (same foot or ankle) NONE
Date of previous injury ___/___ Describe _____
When present problem began was this previous problem completely resolved? Yes No

FOOT AND ANKLE HISTORY
(General History)

GENERAL MEDICAL HISTORY

MEDICAL ILLNESSES/CONDITIONS: NONE Check as many as are applicable

- | | |
|--|---|
| <p>Gout ----- <input type="checkbox"/></p> <p>Psoriasis ----- <input type="checkbox"/></p> <p>Heart disease (type) _____ <input type="checkbox"/></p> <p>High blood pressure ----- <input type="checkbox"/></p> <p>Bad circulation in feet ----- <input type="checkbox"/></p> <p>Bad leg veins (Varicose, Phlebitis, DVT) ----- <input type="checkbox"/></p> <p>Bleeding disorder/tendency ----- <input type="checkbox"/></p> <p>Anemia ----- <input type="checkbox"/></p> <p>Ankle swelling ----- <input type="checkbox"/></p> <p>Lung disease (type, include embolus, asthma, etc.) ----- <input type="checkbox"/></p> <p>Stomach/intestinal (type) _____ <input type="checkbox"/></p> <p>Kidney disease (type) _____ <input type="checkbox"/></p> <p>Arthritis, Degenerative ----- <input type="checkbox"/></p> <p>Arthritis, Rheumatoid (Blood Test Postive) ----- <input type="checkbox"/></p> <p>Arthritis, Other (Lupus, etc.) (type) _____ <input type="checkbox"/></p> <p>Diabetes ----- <input type="checkbox"/></p> | <p>Bladder problems (type) _____ <input type="checkbox"/></p> <p>Seizures ----- <input type="checkbox"/></p> <p>Stroke ----- <input type="checkbox"/></p> <p>Liver disease (hepatitis, etc.) ----- <input type="checkbox"/></p> <p>Glaucoma ----- <input type="checkbox"/></p> <p>Neurological (type) _____ <input type="checkbox"/></p> <p>Psychiatric illness (type) _____ <input type="checkbox"/></p> <p>Cancer (type) _____ <input type="checkbox"/></p> <p>Thyroid disease (type) _____ <input type="checkbox"/></p> <p>Hyperthermia (with anesthesia) ----- <input type="checkbox"/></p> <p>Previous MRSA infection ----- <input type="checkbox"/></p> |
| | Age at onset ____ Years |
| | Age at onset ____ Years |
| | Age at onset ____ Years Insulin Yes <input type="checkbox"/> No <input type="checkbox"/> |

Other _____

CURRENT PRESCRIPTIONS: NONE

Name of medication (Include Insulin)	Duration of use	
_____	Months _____	Years _____
_____	Months _____	Years _____
_____	Months _____	Years _____
_____	Months _____	Years _____
_____	Months _____	Years _____
_____	Months _____	Years _____

ASPIRIN (Anacin, Empirin)? Yes more than 10 tablets/month Yes less than 10 tablets/month No

PAST STEROIDS: I have taken steroid pills in the past. Yes No

ALLERGIES: NONE
(include medicine, adhesive tape, iodine products, xray dyes, foods, etc.)

Medication, etc.	Reactions -----			
_____	Rash <input type="checkbox"/>	Anaphylaxis <input type="checkbox"/>	Nausea <input type="checkbox"/>	Other _____
_____	Rash <input type="checkbox"/>	Anaphylaxis <input type="checkbox"/>	Nausea <input type="checkbox"/>	Other _____
_____	Rash <input type="checkbox"/>	Anaphylaxis <input type="checkbox"/>	Nausea <input type="checkbox"/>	Other _____
_____	Rash <input type="checkbox"/>	Anaphylaxis <input type="checkbox"/>	Nausea <input type="checkbox"/>	Other _____
_____	Rash <input type="checkbox"/>	Anaphylaxis <input type="checkbox"/>	Nausea <input type="checkbox"/>	Other _____

FOOT AND ANKLE HISTORY (General History)

OTHER ORTHOPAEDIC PROBLEMS: None

Back Shoulder R L Arm R L Hand R L
 Neck Hip R L Knee R L Leg R L

Describe other

orthopaedic problems _____

OPERATIONS: (other than foot and ankle) NONE

1. Date ___/___/___ Type _____
Complications (Including anesthetic)? _____
2. Date ___/___/___ Type _____
Complications (Including anesthetic)? _____
3. Date ___/___/___ Type _____
Complications (Including anesthetic)? _____
4. Date ___/___/___ Type _____
Complications (Including anesthetic)? _____

OTHER HOSPITALIZATIONS: (other than for surgery or childbirth) NONE

1. Date ___/___/___ Diagnosis _____
2. Date ___/___/___ Diagnosis _____
3. Date ___/___/___ Diagnosis _____

TOBACCO/ALCOHOL/RECREATIONAL DRUG USE/HIV RISK FACTORS:

- I have never smoked. I am a smoker. (____ packs per day) # Years Smoking ____
 I have been a smoker and I stopped smoking in (year) _____
 I do not use alcohol.
 I drink alcohol occasionally.
 I drink 3 or more alcoholic beverages per day, several times a week.

FAMILY HISTORY: Do/did any "blood relatives" have any of the following? None to list

Disease	Relationship	Comment
Cancer -----	<input type="checkbox"/> _____	_____
Heart disease -----	<input type="checkbox"/> _____	_____
Diabetes -----	<input type="checkbox"/> _____	_____
Arthritis -----	<input type="checkbox"/> _____	_____
Bone disease -----	<input type="checkbox"/> _____	_____
Foot or ankle problem-----	<input type="checkbox"/> _____	_____
Hyperthermia (with anesthesia) ----	<input type="checkbox"/> _____	_____
Other -----	<input type="checkbox"/> _____	_____

FOOT AND ANKLE HISTORY

(General History)

SOCIAL HISTORY:

Home members

- Live alone
- Live with family members (relationship(s)) _____
- Other _____

Height _____ Weight _____ Shoe Size _____ Width _____

PLEASE USE THIS SPACE FOR ADDITIONAL PERTINENT INFORMATION OR SPECIFIC QUESTIONS YOU WISH TO ASK.

Signature of patient, guardian or witness