

Family Foot & Ankle Care of Jasper, PC

Personal Information:

Name and Address: _____
 Phone: _____ Cell Phone: _____ Email: _____
 Date of Birth: _____ Social Security Number: _____ Age: _____
 Sex: Female Male Marital Status: Single Married Widowed Divorced
 Emergency Contact/Relationship: _____ Phone: _____
 Preferred Pharmacy: _____
 Primary Care Physician Name: _____ Location: _____
 How were you referred to our office? _____
 Employer: _____ Work Related Injury? Yes No
 Height: _____ Weight: _____ Shoe Size: _____

Social: Do you use Tobacco products? **Yes No** Do you drink Alcoholic beverages? **Yes No**

Reason for visit today? _____ Are you in Pain? **Yes No**

Medical History:

List **ALL** Medical Allergies and Reaction: _____

List **ALL** Medications: _____

Have you had a LOWER EXTREMITY surgery (hip, knee, ankle, foot): **Yes No**
 •If yes, please provide date and type of surgery: _____

Your Medical History and Family Medical History: (check all boxes that apply)

Condition	You	Family	If Yes, please list condition/family member:
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	
Heart Trouble	<input type="checkbox"/>	<input type="checkbox"/>	
Kidney or Liver Problem(s)	<input type="checkbox"/>	<input type="checkbox"/>	
Asthma/Lung Problem(s)	<input type="checkbox"/>	<input type="checkbox"/>	
Stomach / Bowel	<input type="checkbox"/>	<input type="checkbox"/>	
Varicose Vein(s)	<input type="checkbox"/>	<input type="checkbox"/>	
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	

Additional Medical Information: _____

ASSIGNMENTS OF BENEFITS

I hereby assign all medical and/or surgical benefits to which I am entitled including Medicare, Private Insurance, and any other health plan to: Dr. Timothy Barry, Family Foot and Ankle Care of Jasper, PC. This assignment will be in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I understand that I am financially responsible for all charges whether or not paid by Insurance. I hereby authorize said assigned to release all information necessary to secure the payment. I understand that all past due account are subject to collection proceedings. All cost incurred including, but not limited to, collection fees, attorney fees, and court fees shall be my responsibility in addition to the balance due to the office.

Signature: _____ Date: _____

Minor Signature of Responsible Party: _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES/HIPPA COMPLIANCE

I acknowledge that I was provided a copy of the Notice of Privacy Practices / HIPPA Compliance and that I have read (or have had the opportunity to read if I chose) and understand the notice.

Signature: _____ Date: _____