FOOT AND ANKLE
ASSOCIATES OF CENTRAL ARKANSAS

Welcome to our office! We appreciate you choosing us!

Today's date: _____ Patient name: _____

Who are you seeing today: ? ☐ Dr. Alex Dellinger ☐ Dr. David Kiessling ☐ Dr. Calvin Britton

SSN#: _____ Date of birth: _____ **M / F**

Person on insurance if other than the patient: _____ their date of birth: _____

** If patient is a minor, who is the parent or legal guardian?* _____

Address: _____ City: _____ State: _____ Zip: _____

Home phone: ( ) _____Cell phone: ( ) _____ Work: ( ) _____

Email Address: _____ Place of employment: _____

Emergency Contact: _____ Phone#: ( ) _____

Preferred pharmacy: _____ Phone#: ( ) _____

Primary Care Physician: _____

Date you were last seen by your Primary Care Physician: _____

Who may we thank for referring you to our practice? _____

Marital Status: *(please circle one)* Single Married Divorced Widowed Other

Primary language spoken: ENGLISH *Other:* _____

Race: _____ Ethnicity: _____

How may we contact you (check all that apply)? :
☐ Phone ☐ Email ☐ Mail ☐ SMS (Text Message)

With whom may we leave a message with if a concern about your care should arise?
☐ Patient only ☐ Patient and/or spouse ☐ other family member _____

Foot & Ankle Associates of Central Arkansas

Why are you here today ?: _____

How severe is your pain? (very mild) 0 1 2 3 4 5 6 7 8 9 10 (severe)

How long have you had this problem? _____

Anything else you want to tell us about your problem: _____

_____

Tell us about your medical history:

Do you have any drug allergies? **Y** or **N** *If yes, please list:* _____

_____

Please check the appropriate box if you are currently being treated for these:

	Y	N		Y	N		Y	N
High blood pressure	☐	☐	Gout	☐	☐	epilepsy or seizures	☐	☐
Stroke/heart attack	☐	☐	Anemia	☐	☐	Circulation problem	☐	☐
Heart problems	☐	☐	Asthma	☐	☐	Thyroid disease	☐	☐
Bronchitis	☐	☐	Liver/hepatitis	☐	☐	Shortness of breath	☐	☐
Arthritis	☐	☐	Kidney/dialysis	☐	☐	HIV/AIDS	☐	☐
Cancer	☐	☐	Stomach/GI	☐	☐	High cholesterol	☐	☐
Parkinson's	☐	☐	Diabetes	☐	☐	Alzheimer's/dementia	☐	☐

Any other not on the list: _____

Please list any major surgeries you have had in the past 10 years:

_____ _____ _____

_____ _____ _____

If you've had surgery before, did you have any type of reaction to any medication or anesthesia or any type of complication related to the surgery? **Y or N**

** If yes, what ?* _____

Height: ? _____ Weight: ? _____ What is your shoe size ? _____

Do you have any family history of medical diseases or problems ? If yes, please fill in:

***On your mother's side*:** _____

***On your father's side*:** _____

Do you drink alcohol? **Y or N** *If yes, how often / much?* _____

Do you smoke? **Y or N** *If yes, how much?* _____

Please answer yes or no:

	Y	N		Y	N		Y	N	
Constitutional:	☐	☐	fever	☐	☐	chills	☐	☐	dizziness
Cardiovascular:	☐	☐	chest pain	☐	☐	murmur	☐	☐	shortness of breath
	☐	☐	stroke	☐	☐	heart attack	☐	☐	other_____
Endocrine:	☐	☐	diabetes	☐	☐	weight loss	☐	☐	excessive thirst
	☐	☐	frequent urination				☐	☐	other_____
Gastrointestinal:	☐	☐	diarrhea	☐	☐	bloody stool	☐	☐	stomach ulcers
	☐	☐	nausea / vomiting	☐	☐	other_____			
Skin:	☐	☐	eczema	☐	☐	psoriasis	☐	☐	rash
	☐	☐	open sores or wounds				☐	☐	other_____
Musculoskeletal:	☐	☐	joint pain	☐	☐	bone problems	☐	☐	arthritis
	☐	☐	muscle problems	☐	☐	weakness	☐	☐	other_____
Neurological:	☐	☐	numbness	☐	☐	tingling / numbness			
	☐	☐	seizures	☐	☐	fibromyalgia			
	☐	☐	other_____						

Please list **all** medications you take, prescription and over the counter:

If you have a list already, you may provide it to a staff member so we may photocopy it instead:

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

☐ Check here if you take **NO** medications.

Permission to treat

I understand and agree (regardless of my insurance status), that I am ultimately responsible for my bill and the professional services provided to me. I understand I am responsible for the balance of my account after adjudication by any insurance I may have. I have read all the information and answered all the questions. I certify this information is true and correct to the best of my knowledge. I also authorize Foot & Ankle Associates to deposit any monies received in my name by my insurance company.

Authorization for Release of Medical Record Information

I understand that sometimes the information contained in my medical record is needed by other parties. These may include attorneys, my insurance company, or other physicians that may be treating me. By signing this form, I authorize Foot & Ankle Associates of Central Arkansas, to submit any information requested by any of the above named entities. I also authorize Foot & Ankle Associates of Central Arkansas to obtain my medication list and/or history, electronically, through their electronic health record, if needed through the course of treatment. I understand that I may revoke this consent at any time, except where information has already been released, by sending a written request to the Office Manager or treating doctor, and the appropriate form signed. The revoked consent will take effect on the date of the signature.

Acknowledgement of Receipt of Notice of Privacy Practices

Copies of the privacy policy are located on the front counter.

I acknowledge that I was offered a copy of the notice of Privacy Practices and that I have read (or had the opportunity to read if so chosen) and understand the Notice.

Financial Policy

Copies of the Financial Policy are located on the front counter.

I acknowledge that I was offered a copy of the Financial Policy and that I have read (or had the opportunity to read if so chosen) and understand the Notice.

By signature, I understand that I have read and agree with the above statements.

Name: _____ Date: _____

If patient is a minor, the legal guardian: _____

Signature: _____