

**CONFIDENTIAL PERSONAL DATA SHEET**

LAST NAME \_\_\_\_\_ FIRST NAME \_\_\_\_\_ MIDDLE \_\_\_\_\_

GENDER M  F  DATE OF BIRTH \_\_\_/\_\_\_/\_\_\_ SS# \_\_\_\_\_

HOME ADDRESS \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_ EMAIL ADDRESS \_\_\_\_\_

HOME PHONE \_\_\_\_\_ CELL PHONE \_\_\_\_\_ WORK PHONE \_\_\_\_\_

EMPLOYER \_\_\_\_\_ OCCUPATION \_\_\_\_\_

PRIMARY CARE PHYSICIAN \_\_\_\_\_ ADDRESS \_\_\_\_\_

PHARMACY Primary with Location: \_\_\_\_\_ Secondary with Location: \_\_\_\_\_

Ethnicity:

Not of Spanish/Hispanic Origin  Spanish/Hispanic Origin  Decline/Unknown Primary Language: \_\_\_\_\_

Race:  White  Black/African American  Asian  Pacific Islander  Patient Declined/Unknown  Other

Single  Married  Widowed

Spouse/Significant Other(Last) \_\_\_\_\_ (First) \_\_\_\_\_ Phone \_\_\_\_\_

Child/Dependent  Parent/Guardian (Last) \_\_\_\_\_ (First) \_\_\_\_\_ Phone \_\_\_\_\_

Parent/Guardian (Last) \_\_\_\_\_ (First) \_\_\_\_\_ Phone \_\_\_\_\_

**EMERGENCY CONTACT**

#1: \_\_\_\_\_ Phone \_\_\_\_\_ #2: \_\_\_\_\_ Phone \_\_\_\_\_

How did you hear about our office? \_\_\_\_\_

I acknowledge and consent that a **PHOTO** may be taken for the purpose of insurance identification:

I decline to have a **PHOTO** taken and will provide my driver's license for identification:

**I authorize ADVANCED REGIONAL CENTER FOR ANKLE & FOOT CARE TO:**

**Leave Appointment message on:**

- On Home Phone  **CHECK**
- On Cell Phone  **ALL**
- On Office Voice Mail  **THAT**
- With Another Person  **APPLY**
- Send Via Mail
- Send Via E-mail
- Send Via Text Message

**Leave other medical info on:**

- On Home Phone
- On Cell Phone
- On Office Voice Mail
- With Another Person
- Send Via Mail
- Send Via E-mail
- Send Via Text Message

HIPPA CONTACT INSTRUCTIONS--Persons ADVANCED REGIONAL CENTER are authorized to communicate with:

NAME: \_\_\_\_\_ PHONE: \_\_\_\_\_ RELATIONSHIP: \_\_\_\_\_

NAME: \_\_\_\_\_ PHONE: \_\_\_\_\_ RELATIONSHIP: \_\_\_\_\_

The **Notice of Privacy** practice is posted in our office for your review. A copy may be provided for you upon request. I understand that I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to conduct, plan and direct my treatment and follow-up among the healthcare providers who may be directly and indirectly involved in providing my treatment, obtain payment from third party payers and conduct normal health care operations such as quality assessments and accreditation. I certify that the above information is correct and I request services.

\_\_\_\_\_  
Signature of patient or person acting on patient's behalf

\_\_\_\_\_  
Date

**FINANCIAL INFORMATION AND AUTHORIZATION**

**PATIENT LAST NAME:** \_\_\_\_\_ **FIRST:** \_\_\_\_\_ **MIDDLE:** \_\_\_\_\_

**FINANCIAL TYPE** (Check all those that apply)

Cash       Group Insurance       Medicare       Auto Injury       Workers Compensation

**INSURANCE**      **We need to scan your insurance cards for our records**

Primary Insurance \_\_\_\_\_

Insured's Name \_\_\_\_\_ Employer \_\_\_\_\_

Secondary Insurance \_\_\_\_\_

Insured's Name \_\_\_\_\_ Employer \_\_\_\_\_

**RESPONSIBLE PARTY (POLICYHOLDER OF INSURANCE)**

Responsible Party or Policyholder \_\_\_\_\_ Date of Birth \_\_\_\_\_

Relationship to Patient \_\_\_\_\_ SS# \_\_\_\_\_

Home Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone # \_\_\_\_\_ Cell Phone # \_\_\_\_\_ Work Phone # \_\_\_\_\_

Employer Name \_\_\_\_\_

**MY FINANCIAL RESPONSIBILITY**

I certify that the above information is correct. I understand that I am personally financially responsible for all services not paid for by my insurance. I am also responsible for any annual deductibles applicable, co-payments or non-covered services as may be required by my insurance plan.

X \_\_\_\_\_  
**Signature** of patient or person acting on patient's behalf      \_\_\_\_\_  
Date

**RELEASE OF MEDICAL INFORMATION AUTHORIZATION**

I authorize the release of any medical or other information necessary to process my claims. I also request payment of government or private benefits either to myself or to the party who accepts assignment. This is a permanent authorization that I may revoke at any time by written notice.

X \_\_\_\_\_  
**Signature** of patient or person acting on patient's behalf      \_\_\_\_\_  
Date

**AUTHORIZATION TO UPDATE MEDICATIONS**

I authorize Advanced Regional Center for Ankle & Foot Care to access my list of medications via Surescripts and enter the information into my chart.

X \_\_\_\_\_  
**Signature** of patient or person acting on patient's behalf      \_\_\_\_\_  
Date

**PATIENT'S MEDICAL HISTORY**

PATIENT NAME: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_

HEIGHT: \_\_\_\_\_ WEIGHT: \_\_\_\_\_ SHOE SIZE: \_\_\_\_\_ HOURS ON FEET DAILY: \_\_\_\_\_

PRESENT FOOT PROBLEM: \_\_\_\_\_

HAVE YOU HAD PREVIOUS TREATMENT FOR THIS PROBLEM? \_\_\_ YES \_\_\_ NO

INJECTION       PHYSICAL THERAPY       MEDICATION       ORTHOTICS  
 SURGERY       OTHER (EXPLAIN) \_\_\_\_\_

IS YOUR CURRENT ANKLE OR FOOT PROBLEM A WORK-RELATED INJURY? \_\_\_ YES \_\_\_ NO

PLACE OF INJURY: \_\_\_\_\_ DATE OF INJURY: \_\_\_\_\_

WORKERS COMP INSURANCE: \_\_\_\_\_ CLAIM #: \_\_\_\_\_

CONTACT PERSON: \_\_\_\_\_ PHONE#: \_\_\_\_\_

**PAST SURGERIES: TYPE OF SURGERY AND DATE**

1 \_\_\_\_\_ Date \_\_\_\_\_ 4 \_\_\_\_\_ Date \_\_\_\_\_

2 \_\_\_\_\_ Date \_\_\_\_\_ 5 \_\_\_\_\_ Date \_\_\_\_\_

3 \_\_\_\_\_ Date \_\_\_\_\_ 6 \_\_\_\_\_ Date \_\_\_\_\_

**PAST ACCIDENTS: TYPE OF ACCIDENT AND DATE**

1 \_\_\_\_\_ Date \_\_\_\_\_

2 \_\_\_\_\_ Date \_\_\_\_\_

**ALCOHOL**     DO NOT USE       1-2 DRINKS/WK       4-5 DRINKS/WK

**TOBACCO**     DO NOT USE  
 CURRENT TOBACCO USE    YEAR TOBACCO USE BEGAN \_\_\_\_\_ PACKS PER DAY \_\_\_\_\_  
 FORMER TOBACCO USE    YEAR TOBACCO USE ENDED \_\_\_\_\_

**DO YOU USE RECREATIONAL DRUGS?**     YES       NO

**CURRENT MEDICATIONS:** Please list **ALL** medications you take as well as the dosage of each and how many tablets are taken each day. You are required to bring a list of your medications with you to **EACH** visit.

MEDICATION	DOSAGE	REASON	MEDICATION	DOSAGE	REASON
1 _____			7 _____		
2 _____			8 _____		
3 _____			9 _____		
4 _____			10 _____		
5 _____			11 _____		
6 _____			12 _____		

