HanoveR
Foot&Ankle
Associates

PATIENT INFORMATION FORM

(PLEASE PRINT)

Date: ____/_____/_____ Social Security #: _____

Patient Name: _____ _____ ____ Date of Birth: ____/____/____ Sex: M F
Last First MI

Home Address: _____ City/State: _____Zip: _____

May we leave a message?
Home Phone: (_____) _____-_____ Yes No
Alternate Phone: (_____) _____-_____ Yes No

May we leave a phone message with:
Patient only_____ Patient and / or spouse_____ Anyone answering the phone_____

Primary Language: _____ Ethnicity: ___Not Specified ___Hispanic/Latino ___Not Hispanic / Latino
Race: ___White ___Amer. Indian/Alaska Native ___Asian ___Black/African Amer. ___Native Hawaiian/Pacific Is.
___Not Specified

Emergency Contact: _____ Relationship: _____ Phone #: (____) _____-_____

Primary Care Doctor: _____ Date last seen: _____ Pharmacy: _____

Who is responsible for payment? _____ Relationship to patient? _____
Address: _____ City/State: _____ Zip: _____
Phone #: (_____) _____-_____ Social Security # _____

Do you have a legal guardian or healthcare power of attorney? Yes No
If yes, Name: _____ Relationship: _____ Phone #: (____) _____-_____

Whom may we thank for referring you to us? _____

Insurance Information
Primary Insurance Company Name: _____
Policy #: _____ Group #: _____
Subscriber: _____ Subscribers Birthdate: _____ SS#: _____

Secondary Insurance Company Name: _____
Policy #: _____ Group #: _____
Subscriber: _____ Subscribers Birthdate: _____SS#: _____

Social History
Marital Status: ☐ Single ☐ Married ☐ Partnered ☐ Separated ☐ Divorced ☐ Widowed

Use of Alcohol: ☐ Never ☐ No longer use ☐ History of alcohol abuse
☐ Current Use - Type _____ ☐ Rare ☐ Occasional ☐ Moderate ☐ Daily

Use of Tobacco: ☐ Never ☐ Quit – how long ago? _____ ☐ Smoke ____ packs/day for ___yrs

Use of Recreational Drugs: ☐ Never ☐ Quit – How long ago? _____ Type _____
☐ Current Use - Type _____ ☐ Rare ☐ Occasional ☐ Moderate ☐ Daily

Employer: _____Occupation: _____ Phone #: (_____) _____-_____
How much are you on your feet at work? ☐ 10% ☐ 25% ☐ 50% ☐ 75% ☐ 100%

Family History

Do you have a family history of: ☐ Diabetes ☐ Cancer ☐ Heart Disease ☐ High Blood Pressure
☐ Stroke ☐ Coronary Artery Disease ☐ Thyroid Disease ☐ Rheumatoid Arthritis
☐ Other _____

Your Medical History

Height:_____ Weight:_____ Shoe Size:_____

Allergies: ☐ None Known ☐ Penicillin ☐ Medications _____
☐ Tape ☐ Latex ☐ Shellfish ☐ Iodine ☐ Other _____
☐ Anesthesia _____ ☐ Foods _____

Place a check mark in the box to indicate if you have ever had any of the following?

	Yes	No		Yes	No		Yes	No
Acid Reflux			Fibromyalgia			Mitral Valve Prolapse		
Anemia			Gout			Neuropathy		
Arthritis			Heart Attack			Open Sores		
Asthma			Heart Disease/Failure			Pneumonia		
Back Trouble			Hepatitis			Polio		
Bladder Infections			HIV+/AIDS			Rheumatic Fever		
Abnormal Bleeding			High Blood Pressure			Skin Disorder		
Blood Clots			High Cholesterol			Sleep Apnea		
Blood Transfusion			Kidney Disease			Stomach Ulcers		
Bronchitis/Emphysema			Liver Disease			Stroke		
Cancer			Low Blood Pressure			Thyroid Disease		
Diabetes			Migraine Headaches			Tuberculosis		
Other Conditions:								

List all medications and dosages you are currently taking (Include prescriptions, over-the-counter meds and herbal supplements):

_____ _____ _____
_____ _____ _____
_____ _____ _____

List all prior surgeries:

Type of Surgery Date Type of Surgery Date Type of Surgery Date

_____ _____ _____
_____ _____ _____
_____ _____ _____

List all prior hospitalizations (other than for surgery)in the last 12 months:

Reason Date Reason Date Reason Date

_____ _____ _____
_____ _____ _____
_____ _____ _____

Current Problem

What specific problem brings you to our office today? _____

Where is the pain/problem located? _____

How long ago did this problem first start? _____ Days / Weeks / Months / Years

Did your pain or problem: ☐ Begin all of a sudden ☐ Gradually develop over time

How would you describe your pain? ☐ No pain ☐ Sharp ☐ Dull ☐ Aching ☐ Burning
☐ Radiating ☐ Itching ☐ Stabbing ☐ Other _____

How would you rate your pain on a scale from 0 to 10? (please circle)
(no pain) 0 1 2 3 4 5 6 7 8 9 10 (worst pain possible)

Since the time your pain or problem began, has it: ☐ stayed the same ☐ become worse
☐ Improved

What makes your pain or problem feel worse? ☐ Walking ☐ Standing ☐ Daily activities
☐ Resting ☐ Dress shoes ☐ High heels ☐ Flat shoes ☐ Any closed toe shoe
☐ Running ☐ Other _____

What makes your pain or problem feel better?_____

What treatments have you had for this problem? _____

How has this problem affected your lifestyle or ability to work?_____

Was this problem caused by an injury? ☐ Yes (describe)_____ ☐ No
If yes, was it a work-related injury? ☐ Yes ☐ No

To the best of my knowledge, I have answered the questions on this form accurately. I understand that providing incorrect information can be dangerous to my health. I understand that it is my responsibility to inform the doctor and office staff of any changes in my medical status.

_____
Print name of Patient, Parent or Guardian

_____ _____
Signature Date

Assignment and Release

I, the undersigned certify that I (or my dependent) have insurance coverage with the above noted insurance and assign directly to Hanover Foot & Ankle associates all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize Hanover Foot & Ankle Associates to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

_____ _____
Responsible Party Signature Date