Island Foot and Ankle Surgery
35 Bill Fries Dr., Unit L
Hilton Head Island, SC 29926
(843)895-2140 FAX: (843) 895-2141

Full Name:

First Middle Last Suffix

Sex: __ Male __Female __Unknown **Date of Birth:**_____/_____/_____

Social Security Number: _____
Phone-
Main: _____ Cell: _____ Work: _____
Email: _____
Address: _____
City: _____ State: _____ ZIP: _____

Marital Status: _____ Maiden Last Name: _____
Spouse Name: _____ Spouse DOB: _____

Driver's License Number: _____ State: _____

DEMOGRAPHICS (optional)
Ethnicity: _____ Race: _____ Language: _____

EMERGENCY CONTACT:

Name: _____ Relationship: _____

Primary Phone: _____ ____Cell ___Home ___ Work
Email: _____
Address: _____
City: _____ State: _____ ZIP: _____

FINANCIAL INFORMATION

Responsible Party-
Who will be financially responsible for you? _____Myself _____ Someone else

If you chose "Someone else" please fill out the following:

Name: _____ Relationship: _____

Phone: _____ (cell, home, work – circle)

Method of Payment:

Self-Pay: ____ Insurance: ___

If you choose "Insurance", please out the following:

Primary Insurance Policy

Name of Insurer: _____
Relationship to Insurer if not self: _____
Insurance Company: _____
Insurance Plan: _____

Policy Number: _____ Group Number: _____

Insurance Address: _____

City: _____ State: _____ ZIP: _____
Insurance Phone Number: _____

Secondary Insurance Policy

Name of Insurer: _____
Relationship to Insurer if not self: _____
Insurance Company: _____
Insurance Plan: _____

Policy Number: _____ Group Number: _____

Insurance Address: _____

City: _____ State: _____ ZIP: _____
Insurance Phone Number: _____

Medical History

Height: _____ Weight: _____ Age: _____ Shoe Size: _____

Please describe your problem and what brought you in:

_____
_____
_____
_____

Have you been under a care if medical doctor in the past two years? Y / N

Primary Physician Name: _____

Address: _____

City: _____ State: _____ ZIP: _____

Phone Number: _____ Fax:
_____

Do you Smoke: Y / N Drink Alcohol: Y / N How often: _____

Recreational drug use: Y / N Do you bruise or bleed easily? Y / N

WOMEN: Are you currently pregnant? Y / N

List of All Surgeries and Complications:

_____
_____
_____
_____

Please Check ALL that apply with **S** – for Self and **F**- for Family

ENT/ EYES

____ Cornea Abrasion
___ Dry eye
___ Deviated Septum
___ Glaucoma

CARDIOVASCULAR

___ Arrhythmia
___ Blood Pressure Abnormality
___ Dizziness with standing or sitting
___ Heart Attack
___ Hypercholesteremia
___ Pace Maker
___ Stroke or CVA
___ Varicose Veins
___ Blood Clots
___ Congestive Heart Failure
___ Extremities Cold
___ Heart Disease
___ Internal Bleeding
___ Poor Circulation
___ Swelling of feet/legs

RESPIRATORY

___ Asthma
___ Emphysema
___ Shortness of Breath
___ Sleep Apnea
___ COPD
___ Persistent Cough
___ Shortness of breath when lying down
___ Tuberculosis

ENDOCRINE

___ Cancer: What type_____
___ Diabetes: Type I or II _____
___ Goiter
___ Hypoglycemia
___ Increased Urination
___ Unexplained weight loss
___ Fatigue
___ Gout
___ Increased Hunger
___ Thyroid Disease

GI/GU

___ Black Stool
___ Constipation
___ Endometriosis
___ irritable bowel syndrome
___ Poor Appetite
___ Vomiting Blood
___ Bloody Stool
___ Diarrhea
___ GERD
___ Liver Disease
___ Stomach Ulcer
___ Frequent Urination
___ Kidney Stones
___ kidney disease

DERMATOLOGY

___ Allergy/Hives
___ Deformed nails
___ Ingrown nail
___ Skin disease
___ Psoriasis
___ Skin Ulceration/Wounds
___ Corns/ Calluses
___ Skin Lesions/rash- itchiness
___ Thick nails

MUSCULOSKELETAL

___ Ankle Sprain
___ Broken Bones
___ Bursitis
___ Fibromyalgia
___ Hammertoes
___ Joint Stiffness
___ Muscle Pain/Weakness
___ Pain standing after rest
___ Painful toes
___ Arthritis
___ Bunions
___ Cramping pain while walking
___ Heel Pain / Foot Pain
___ Lower back pain
___ Osteoporosis
___ Flat feet
___ Clubfoot or congenital birth defects

NEUROLOGICAL

___ Burning Pain
___ Numbness
___ Seizures
___ Dementia
___ Pin and Needles/ Tingling
___ Weakness or flaccidness
___ Spasms
___ Stumbling/ Falling difficult walking

HEMATOLOGIC/LYMPHATIC

___ Anemia
___ Fever/Chills
___ Hepatitis A, B, C - circle
___ Bleeding Disorder
___ HIV
___ Leukemia

PSYCHIATRIC

___ Anxiety
___ Depression
___ Bi-polar Disorder
___ Paranoia

MEDICATIONS

Please list ***Allergies***:

_____
_____
_____
_____

Please list your preferred pharmacies in order-

Name of Pharmacy	Address	Phone Number

Please list name of medications-

Medication	Dosage

I hereby give permission to the doctors to administer such procedures as may be deemed necessary in the diagnosis and the treatment of my condition. Furthermore, I acknowledge that I am fully responsible for all deductibles and portion of medical expenses not covered by my insurance company.

To the best of my knowledge, all preceding answers are true and correct. If I ever have any changes in my health or medications, I will inform the doctor and staff at next appointment.

_____ _____

Patient Signature Date

The "Health Insurance Portability and Accountability Act" (HIPPA) gives individual the right to request a restriction on use and disclosure of "Personal Health Information" (PHI). The individual is also provided the right to request confidential communication of PHI to be made by alternative means, such as correspondence to the individuals work instead of home.

The Privacy Ule generally requires Healthcare providers to take steps to limit their use and disclosure of your PHI.

Note Use and Disclosure for emergencies may be permitted without prior consent.

I wish to be contracted in the following manner: (please check all that apply)

___ Home Phone: _____

___ Cell Phone: _____

___ Work Phone: _____

___ Other Phone: _____

___ Okay to leave basic message with call back number

___ Okay to leave detailed message with specific information

Written & Electronic Communications:

___ Okay to email information to my home address (see patient information form for address)

___ E mail address: _____

The following individuals may have access to my "Personal Health Information" (PHI):

Name	Relationship	Phone Number
_____	_____	_____
_____	_____	_____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE PRIVACY PRACTICE

By Signing my name below, I acknowledge that I received a copy of this office's "Notice of Privacy Practices" outlining how my confidential PHI will be used, disclosed and protected.

X_____ _____

Patient Signature Date