Welcome to Jackson Family Foot & Ankle Care

Patient Information

Patient Name: _____ **D.O.B:** _____ **SSN:** _____

Home Address: _____ **Apartment:** _____

City: _____ **State:** _____ **Zip Code**: _____

Home Phone: _____**Cell Phone:** _____

Email Address: _____

Would you like access to your records online through our secure patient portal? ☐ Yes ☐ No

Sex: ☐ Male ☐ Female **Marital Status:** ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated

Preferred Language: _____

Ethnicity: ☐ Hispanic/Latino ☐ Not Hispanic/Latino ☐ Unreported/Refused to Report

Race: ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ More than one race

☐ Native Hawaiian ☐ Pacific Islander ☐ White ☐ Unreported/Refused to Report

Primary Physician: _____Phone: _____

Specialty Doctors:_____

Pharmacy: _____ Phone: _____

Emergency Contact _____ Emergency Phone _____

Disclosure to Designated Family/Friends Caregivers

I allow Jackson Family Foot & Ankle Care to disclose medical information as needed to the following designed individual(s) involved with my health care. I understand that I am not required to list anyone. I also understand that I may change my list in writing at any time.

Print Name: _____ Relationship: _____Phone #: _____

Print Name: _____ Relationship: _____Phone #: _____

Insurance Information

Insurance Carrier _____ Group # _____ ID #_____

Person Responsible for Account _____

Relationship to Patient _____ D.O.B _____ SSN _____

Address (if different from patient) _____

Secondary Insurance _____ Group _____ ID # _____

Person Responsible for Account _____

Relationship to Patient _____ D.O.B _____ SSN _____

Is this a compensation or work relate case? ☐ Y ☐ N Date of Injury _____

Review of Symptoms

Name: _____ **D.O.B:** _____

Shoe Size: _____ **Height:** _____ **Weight:** _____

What type of shoes do you wear most often? _____

- What is your chief complaint you are here to address today? _____

_____

_____

- Description of Pain (dull, sharp, aching, etc.): _____
- Aggravating Factors (when is the pain at its worst?) _____
- How long has this bothered you? _____Days _____Weeks _____Months _____Years
- Relieving Factors: ☐ Rest ☐ Ice ☐ Heat ☐ Medications ☐ Home Remedies ☐ Stretching ☐ Other:_____
- Does your foot pain limit your activities? ☐ Yes ☐ No Do you have difficultly/pain walking? ☐ Yes ☐ No
- Have you had any previous treatment for this problem? ☐ Yes ☐ No

  If yes, please explain: _____
- Have you had diagnostic imaging for this problem? ☐ Yes ☐ No

  If yes, when and where were they done? _____
- Please indicate which foot problems you now have or have had in the past:

☐ Ankle Pain
☐ Ankle Instability (Easy Twisting Injuries)
☐ Ankle Swelling or Stiffness
☐ Achilles Tendon Pain
☐ Pale or Blue Discoloration of the Feet
☐ Swelling in Feet or Ankles
☐ Ingrown Toenails
☐ Athlete's Foot
☐ Corns/Calluses
☐ Plantar Wart
☐ Heel or Arch Pain
☐ Cramps in Feet or Legs
☐ Leg Pain
☐ Tired Feet
☐ Bunions
☐ Flat Feet
☐ Numbness in Feet/Toes or Legs
☐ "Toe-in"or"Toe-out" Gait (Walking)
☐ Pain or Fatigue of Feet or Legs During Activity or Exercise
☐ Non/Poor Healing Sore, Ulcer or Gangrene on the Leg or Foot

- Have your ever been to a podiatrist before? ☐ Yes ☐ No

  Last Visit? _____

Medical History

Name: _____ **D.O.B:** _____

Please indicate with a (✓) any of the medical conditions below that pertain to you

☐ Abdominal Aortic Aneurysm	☐ COPD	☐ High Cholesterol	☐ Rash
☐ AIDS/HIV	☐ CVA (Stroke)	☐ Hypertension	☐ Rheumatic Arthritis
☐ Allergies (Seasonal)	☐ Depression	☐ Keloids/Thick Scars	☐ Rheumatic Fever
☐ Anemia	☐ Diabetes	☐ Kidney Disease	☐ Sciatica
☐ Angina	☐ Diverticulitis	☐ Liver Disease	☐ Sinus Problems
☐ Anxiety	☐ DNR	☐ Low Blood Pressure	☐ Skin Disorder
☐ Arthritis	☐ Edema	☐ Lyme's Disease	☐ Sleep Apnea
☐ Artificial Heart Valves/Joints	☐ Epilepsy	☐ Macular Degeneration	☐ Stomach Ulcers
☐ Asthma	☐ Fainting	☐ Mitral Valve Prolapse	☐ Thyroid Disease
☐ Atrial Fibrillation	☐ Fracture	☐ Neuropathy	☐ Tuberculosis
☐ Back Problems	☐ GERD	☐ Osteopenia	☐ Vascular Disease
☐ Benign Prostatic Hypertrophy	☐ Glaucoma	☐ Osteoporosis	☐ Varicose Veins
☐ Blood Disorder	☐ Gout	☐ Palpitations	☐ Venereal Disease
☐ Blood Clots/DVT/PE	☐ Headaches	☐ Phlebitis	☐ Weight Loss
☐ Cancer	☐ Hearing/Ear Problems	☐ Pneumonia	☐ Other: _____
☐ Cardiomyopathy	☐ Heart Disease	☐ Polio	_____
☐ Chemical Dependency	☐ Heart Murmur	☐ Psychiatric Care	_____
☐ Circulation Problems	☐ Hemophilia	☐ Pulmonary Nodule	_____
☐ Congestive Heart Failure	☐ Hepatitis	☐ Radiation Treatment	_____

Surgical History

☐ Amputation of Foot or Toes	☐ Foot Surgery	☐ Open Heart Surgery
☐ Ankle Surgery	☐ Fracture Repair	☐ Organ Transplant
☐ Bariatric Surgery	☐ Hammertoe Surgery	☐ Pacemaker/Defibrillator
☐ Bunion Surgery	☐ Hip Replacement	☐ Vein Surgery
☐ Colon Surgery	☐ Knee Replacement	

Please list all other surgeries: _____

Allergies

Are you allergic or sensitive to any of the following: ☐ No Known Drug Allergies

☐ Penicillin	☐ Sulfa	☐ Tape	☐ Latex	☐ Betadine (iodine)	☐ Aspirin	☐ Tylenol
☐ Ibuprofen	☐ Vicodin	☐ Codeine	☐ Local or General Anesthesia		☐ Other: _____	

Medication List

Please list current medications prescribed by a doctor, including over the counter medications, vitamins, and supplements: _____

_____

_____

Social History

Name: _____ **D.O.B:** _____

Please indicate with a (✓) any of the responses below that pertain to you

- Tobacco Use:
  - Cigarettes: ☐ Never Smoked
    ☐ Current Smoker _____Packs per day _____Number of Years
    ☐ Former Smoker _____Number of Years _____Quit Date
  - Other Tobacco: ☐ Vape ☐ Pipe ☐ Cigar ☐ Snuff ☐ Chew
  - Are you interested in quitting? ☐ Not Ready to Quit
    ☐ Thinking about Quitting
    ☐ Ready to Quit
- Alcohol: ☐ None ☐ Rarely ☐ Moderate ☐ Quit
- Drug Use: ☐ Yes ☐ No
- Exercise:
  - Do you exercise daily regularly: ☐ Yes, List Activities:_____ ☐ No

Family History

Please indicate with a (✓) for any responses below that pertain to your family members

Medical Condition	Father	Mother	Siblings	Children
Living				
Deceased				
AAA-Abdominal Aortic Aneurysm				
Cancer				
CHF – Congestive Heart Failure				
COPD				
Diabetes				
DVT				
Gout				
Heart Disease				
Hypertension				
Thyroid Disease				
Unknown				

Authorization to Access Electronic Prescription Records

I authorize Jackson Family Foot & Ankle Care and Dr. Christopher Blakeslee to view my external prescription history via electronic prescribing services. I understand that prescription history from multiple other unaffiliated medical providers, insurance companies, pharmacies and pharmacy benefit managers may be viewable by my provider and staff here. It may include prescriptions back in time for several years and may include prescriptions to treat HIV, substance abuse and psychiatric conditions, if applicable. I understand that my prescription history will become part of my Jackson Family Foot & Ankle Care medical record.

Health Information Exchange (HIE)

Jackson Family Foot & Ankle Care also participates in electronic health information exchanges (HIEs) with hospitals and various other health care providers. I authorize Jackson Family Foot & Ankle Care and the HIEs with which it participates to share my health information, through the HIE networks, for purposes permitted by law, including my treatment and coordination of my care, with all health care providers that are authorized under the HIEs' policies and applicable law to access my information. I understand and agree that the information about me that may be shared and accessed through the HIEs may include information about HIV/AIDS status, sexually transmitted diseases, family planning, mental health treatment, genetic test results, use of alcohol and other substances and other sensitive categories of my health information. I understand that I have the right to "opt-out" of having my information shared through HIEs.

Authorization to Release Information and Assignment of Benefits

I hereby give Jackson Family Foot & Ankle Care and Dr. Christopher Blakeslee permission to administer the necessary treatment in order to diagnose and treat my present foot condition after it has been explained to me. I also authorize Jackson Family Foot & Ankle Care and Dr. Christopher Blakeslee to furnish information to insurance carriers concerning my medical condition and treatments and to my referring physician if so requested. I hereby assign to the physician all payments for medical services rendered to my dependents or myself. **I understand I am responsible for any amount not covered by my insurance.** If I am under the Medicare program, I understand not all podiatry services are covered, and further Medicare could determine the services rendered by this office to be medically unnecessary. However, I believe those services to be of benefit, and therefore assume responsibility for payment**. I understand if 24-hour notice is not given for any cancellation or missed appointment, I will be subject to a $25.00 cancellation fee. I understand that a $10.00 monthly service fee will be charged for all outstanding balances which are 30 days past due. If my account is past due 90 days, a $50.00 collection fee will be charged and my account will be placed in collections**

Consent to Treat

I, the underlying, voluntarily consent to and authorize Dr. Christopher Blakeslee and the employees of Jackson Family Foot & Ankle Care to provide such podiatric care and examinations, on a continuing basis, and to administer such routine diagnostic, radiological and/or therapeutic procedures, test and treatments as are considered necessary or advisable, in my diagnosis, care and treatment, in the judgement of Dr. Christopher Blakeslee, including, but not limited to, collecting and testing specimens, and administration of pharmaceutical products. I acknowledge that no guarantees have been made to me about the results of any examination or treatment.

Acknowledgements and Agreement

Please initial the following stating you have read and agreed to the above sections;

_____I acknowledge receipt of the Jackson Family Foot & Ankle Care Financial Policy, and agree to all the terms and conditions contained therein.

_____I acknowledge receipt of the Notice of Privacy Practices.

_____I agree to allow access to my electronic prescriptions records.

_____I agree to allow access to HIE.

_____I agree to the release and assignment of benefits as described above.

_____I agree to treatment as described above.

_____I have read this form, my questions have been answered, and I understand and agree to its content.

Print Patient/Representative's Name: _____**D.O.B:** _____

Patient/Representative's Signature: _____**Date:** _____

If signed by Authorized Representative, print name of Signatory Patient: _____

Relationship to Patient/Authority to Sign for: _____