

# New Patient Questionnaire

## Foot & Ankle

Name:		DOB:
Height:	Weight:	Age:

Occupation: \_\_\_\_\_

Full-time	Part-time
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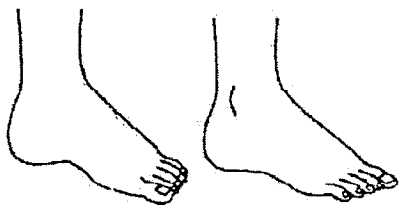
### Chief Complaint

What is the reason for your visit? \_\_\_\_\_

Current Pain Level (no pain 0 – 10 highest):

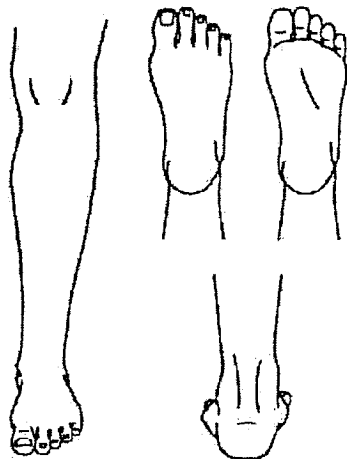
0	1	2	3	4	5	6	7	8	9	10
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Please mark on the body diagram where you are experiencing pain:



When did this condition start? \_\_\_\_\_

Please explain how this condition started: \_\_\_\_\_



Does anything make the pain better? \_\_\_\_\_

Does anything make the pain worse? \_\_\_\_\_

Do you wear Orthotics? Yes No

Please list any work activities, sports, or hobbies that are limited by your current problem: \_\_\_\_\_

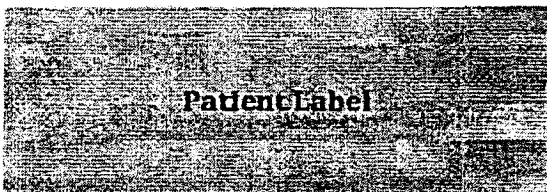
What is your level of play?

Professional	College
High School	Recreational

Have you tried any of the following?

Type	Date Range	Location/Describe	Effective?	
Anti-Inflammatory Medications			Yes	No
Cold Application			Yes	No
Injections			Yes	No
Physical Therapy			Yes	No
Other:			Yes	No

# PATIENT REGISTRATION FORM



PATIENT DEMOGRAPHICS					
NAME (AS LISTED ON IDENTIFICATION)		PREFERRED NAME		DATE OF BIRTH	SOC. SEC. NUMBER
SEX ASSIGNED AT BIRTH <input type="checkbox"/> FEMALE <input type="checkbox"/> MALE <input type="checkbox"/> INTERSEX	SEX LISTED WITH HEALTH INSURANCE <input type="checkbox"/> FEMALE <input type="checkbox"/> MALE	WHAT IS YOUR GENDER IDENTITY? <input type="checkbox"/> SAME AS SEX LISTED WITH INSURANCE <input type="checkbox"/> OTHER: _____		PREFERRED PRONOUNS <input type="checkbox"/> She/Her <input type="checkbox"/> Ze/Hir <input type="checkbox"/> He/His/Him	
PERMANENT STREET ADDRESS			CITY	STATE	ZIP CODE
COUNTRY	HOME PHONE	CELL PHONE	E-MAIL ADDRESS	<input type="checkbox"/> MYCHART <input type="checkbox"/> DISCHARGE INSTRUCTIONS <input type="checkbox"/> DECLINE	
TEMPORARY ADDRESS (IF APPLICABLE)			CITY	STATE	ZIP CODE
GENERAL INFORMATION					
HISPANIC ETHNICITY? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> UNKNOWN <input type="checkbox"/> DECLINE		RACE	ADDITIONAL RACE	ETHNICITY	
FURTHER DESCRIPTION OF ETHNICITY # 1		FURTHER DESCRIPTION OF ETHNICITY # 2		RATE YOUR ABILITY TO SPEAK AND UNDERSTAND ENGLISH <input type="checkbox"/> VERY WELL <input type="checkbox"/> WELL <input type="checkbox"/> NOT WELL <input type="checkbox"/> NOT AT ALL <input type="checkbox"/> DECLINED <input type="checkbox"/> UNAVAILABLE	
WHAT IS YOUR PREFERRED SPOKEN LANGUAGE FOR HEALTH CARE INSTRUCTIONS?			IN WHAT LANGUAGE WOULD YOU PREFER READING HEALTH CARE INSTRUCTIONS?		
WOULD YOU LIKE AN INTERPRETER FREE OF CHARGE? <input type="checkbox"/> YES <input type="checkbox"/> NO		RELIGION	WOULD YOU LIKE RELIGIOUS SERVICES DURING INPATIENT STAY? <input type="checkbox"/> YES <input type="checkbox"/> NO		
MARITAL STATUS	VISUALLY IMPAIRED? <input type="checkbox"/> YES <input type="checkbox"/> NO	PLEASE LIST ANY VISUAL OR HEARING NEEDS			
PATIENT CONTACTS					
PRIMARY CARE PROVIDER (PCP)		PCP TELEPHONE NUMBER	NOTIFY PCP OF ADMISSION? <input type="checkbox"/> YES <input type="checkbox"/> NO	NOTIFY PCP OF RESULTS? <input type="checkbox"/> ALL <input type="checkbox"/> ABNORMAL <input type="checkbox"/> NONE	
REFERRING PROVIDER		REFERRING PROVIDER TELEPHONE			
PATIENT'S EMPLOYER	PATIENT OCCUPATION		<input type="checkbox"/> FULL-TIME <input type="checkbox"/> PART-TIME	RETIREMENT DATE	
			<input type="checkbox"/> RETIRED <input type="checkbox"/> STUDENT		
EMPLOYER ADDRESS (no., street, city, state, zip code)				EMPLOYER PHONE	
EMERGENCY CONTACT					
FULL NAME CONTACT #1		ADDRESS (no., street, apt#, city, state, zip code)			
HOME PHONE	WORK NUMBER	CELL PHONE	RELATIONSHIP TO PATIENT	LEGAL GUARDIAN? <input type="checkbox"/> YES <input type="checkbox"/> NO	SUPPORT PERSON? <input type="checkbox"/> YES <input type="checkbox"/> NO
FULL NAME CONTACT #2		ADDRESS			
HOME PHONE	WORK NUMBER	CELL PHONE	RELATIONSHIP TO PATIENT	LEGAL GUARDIAN? <input type="checkbox"/> YES <input type="checkbox"/> NO	SUPPORT PERSON? <input type="checkbox"/> YES <input type="checkbox"/> NO

**GUARANTOR (The person responsible for the bill)**

GUARANTOR FULL NAME			ADDRESS (no., street, apt#, city, state, zip code)		
RELATIONSHIP TO PATIENT	DATE OF BIRTH	SEX	SOCIAL SECURITY NUMBER	HOME PHONE	CELL PHONE
EMPLOYER		OCCUPATION		<input type="checkbox"/> FULL-TIME <input type="checkbox"/> PART-TIME	RETIREMENT DATE
				<input type="checkbox"/> RETIRED <input type="checkbox"/> STUDENT	
EMPLOYER ADDRESS (no., street, city, state, zip code)					EMP PHONE

**VISIT INFORMATION**

VISIT RELATED TO AN ACCIDENT OR INJURY? <input type="checkbox"/> YES <input type="checkbox"/> NO	INJURED BODY PART: <input type="checkbox"/> RIGHT <input type="checkbox"/> LEFT	HOW DID YOUR INJURY OCCUR?
DATE OF INJURY	TIME OF INJURY	PLACE OF INJURY

**INSURANCE INFORMATION**

<b>PRIMARY INSURANCE</b>				
SUBSCRIBER NAME	RELATIONSHIP TO PATIENT	SEX	DATE OF BIRTH	EMPLOYER
INSURANCE COMPANY NAME			PHONE NUMBER	
INSURANCE COMPANY ADDRESS			NAME OF CLAIMS ADJUSTER (if applicable)	
POLICY NUMBER	GROUP/PLAN NUMBER	CLAIM NUMBER (if applicable)	CASE NUMBER	

**SECONDARY INSURANCE**

SUBSCRIBER NAME	RELATIONSHIP TO PATIENT	SEX	DATE OF BIRTH	EMPLOYER
INSURANCE COMPANY NAME			PHONE NUMBER	
INSURANCE COMPANY ADDRESS			POLICY NUMBER	GROUP/PLAN NUMBER

**TERTIARY INSURANCE**

SUBSCRIBER NAME	RELATIONSHIP TO PATIENT	SEX	DATE OF BIRTH	EMPLOYER
INSURANCE COMPANY NAME			PHONE NUMBER	
INSURANCE COMPANY ADDRESS			POLICY NUMBER	GROUP/PLAN NUMBER

**WORKER'S COMPENSATION/NO FAULT INSURANCE**

SUBSCRIBER NAME	RELATIONSHIP TO PATIENT	SEX	DATE OF BIRTH	EMPLOYER
INSURANCE COMPANY NAME			PHONE NUMBER	
INSURANCE COMPANY ADDRESS			NAME OF CLAIMS ADJUSTER (if applicable)	
POLICY NUMBER	GROUP/PLAN NUMBER	CLAIM NUMBER (if applicable)	CASE NUMBER	

**Medical and Family History**

Please select any past medical conditions and list any family members (mother, father, etc.) below:

Condition	You	Family Member	Condition	You	Family Member
Anxiety	Yes		Open Wounds/Ulcers	Yes	
Arrhythmia (Irregular heartbeat)	Yes		Osteoarthritis	Yes	
Asthma	Yes		Osteoporosis	Yes	
Bleeding Problems	Yes		Peripheral Vascular Disease	Yes	
Blood Clots (DVT)	Yes		Pneumonia	Yes	
Cancer	Yes		Psychiatric Illness (Depression)	Yes	
Diabetes	Yes		Pulmonary Embolus	Yes	
Heart Attack	Yes		Reflex Sympathetic Dystrophy	Yes	
Heart Disease	Yes		Reflux	Yes	
High Blood Pressure	Yes		Rheumatoid Arthritis	Yes	
High Cholesterol	Yes		Seizures	Yes	
Infection	Yes		Stroke	Yes	
Kidney Disorders	Yes		Ulcers	Yes	
Lung Disease	Yes		Other:	Yes	

*For Females Only:* Do you think you may be pregnant at this time?

Yes No

Medication	Route (oral, injection, etc.)	Dose	Frequency
1.			
2.			
3.			
4.			
5.			

Allergy	Reaction
1.	
2.	
3.	
4.	
5.	

**Surgical and Hospitalization History**

Previous Operation/Hospitalization	Occurrence Date (approx.)	Any Complications?
1.		
2.		
3.		
4.		
5.		

**Social History**

Are you a tobacco user? Yes No

Do you consume alcohol? Yes No

If yes, how many drinks per week? \_\_\_\_\_

Do you use any recreational drugs? Yes No

If yes, what kind(s): \_\_\_\_\_

**Review of Systems**

Are you currently having, or have you had problems in the past year with (select all that apply):

Constitutional	ENT	Eyes	Respiratory
Activity Change	Ear pain	Pain	Shortness of breath
Weight Change	Nosebleeds		Wheezing
None	None	None	None

Cardiovascular	Gastrointestinal	Endocrine	Genitourinary
Chest pain	Blood in stool	Excessive thirst	Difficult urination
Leg swelling	Heartburn	Excessive hunger	Frequent urination
Palpitations			
Poor circulation			
Pacemaker			
None	None	None	None

Skin	Neurological	Hematologic	Psychiatric
Healing Problems	Numbness	Bruises	Nervous/Anxious
Wound	Unsteady Walking	Excessive bleeding	Depression
None	None	None	None

**Foot and Ankle Orthopaedic Surgery, P.C.**  
420 East 72<sup>nd</sup> Street New York, NY 10021

212-203-0740  
Fax 212-203-0743

Martin J. O'Malley, MD  
Andrew J. Elliott, MD  
Donna J. Astion, MD

**PRESCRIPTION DRUG CONSENT FORM**

"I agree that Foot & Ankle Orthopaedic Surgery, PC may request and use my prescription medication history from other healthcare providers or third-party pharmacy benefit payors for treatment purposes."

Patient's Name \_\_\_\_\_

Date:

*Effective Date: April 14, 2003*  
*Revision Date: February 7, 2017*

### Acknowledgement of Receipt of Notice of Privacy Practices

Respect for our patients' privacy has long been highly valued at Foot and Ankle Orthopaedic Surgery, PC. Not only is it what our patients expect, it is the right way to conduct health care. As required by law, we will protect the privacy of health information that may reveal your identity and provide you with a copy of our Notice of Privacy Practices that describes the health information privacy practices of our Facility and its medical staff and affiliated health care providers when providing health care services for our Facility. Our Notice will be posted in the office.

By signing below, I acknowledge that I have been provided a copy of this Notice and have therefore been notified of how health information about me may be used and disclosed by the office, and how I may obtain access to and control this information. I also acknowledge and understand special privacy protections apply to HIV-related information, alcohol and substance abuse treatment information, mental health information, and genetic information. Finally, by signing below, I consent to use and/or disclosure of my health information as described in this Notice, including to treat me and arrange for my medical care, to seek and receive payment for services given me, and for the business operations of the Office and its staff.

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Signature of Patient or Personal Representative

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Print Name of Patient or Personal Representative

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Description of Personal Representative's Authority

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Date

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For Office Use Only: If the patient does not sign this acknowledgement form, record here the good faith efforts made to obtain this acknowledgement and consent.

# Pharmacy Information

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With the installation of Epic, the new electronic medical record system, at this practice, your doctor is now able to e-prescribe. This means that any prescriptions the doctor may give you today will be automatically routed to the pharmacy of your choice and we will no longer have to provide you with handwritten prescriptions.

Please complete the information below:

Patient Name: \_\_\_\_\_

Preferred Pharmacy	
Name of Pharmacy:	
Address:	
City:	
State:	
Zip Code:	
Phone Number:	
Fax Number:	

Alternate Pharmacy	
Name of Pharmacy:	
Address:	
City:	
State:	
Zip Code:	
Phone Number:	
Fax Number:	