BASIC PATIENT INFORMATION

PATIENT'S SOCIAL SECURITY NUMBER: _____ DATE _____

NAME OF PATIENT: _____
First Middle Last

BIRTH DATE: _____ AGE: _____

MAILING ADDRESS: _____

STREET ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

HOME PHONE: _____ CELL PHONE: _____ WORK: _____

HEIGHT: _____ WEIGHT: _____

EMAIL ADDRESS: _____ PHARMACY: _____

BILLING INFORMATION/ RESPONSIBLE PARTY/ GUANTOR

RESPONSIBLE PARTY:

_____
(If different than patient) First Middle Last

MAILING ADDRESS: _____

STREET ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

BIRTH DATE: _____ RESPONSIBLE PARTY'S SSN: _____

HOME PHONE: _____ CELL PHONE: _____ WORK PHONE: _____

NAME OF INSURANCE: _____

POLICY NUMBER: _____ GROUP NUMBER: _____

PATIENT'S REALTIONSHIP TO POLICYHOLDER: ___Self ___Child ___Spouse ___Guardian ___Other

NAME OF POLICYHOLDER: _____ GENDER: ___M ___F
(If different from Responsible Party)
BIRTHDATE OF POLICYHOLDER: _____ PHONE NUMBER: _____

INSURANCE COVERAGE-SECONDARY

NAME OF INSURANCE: _____

POLICY NUMBER: _____ GROUP NUMBER: _____

PATIENT'S RELATIONSHIP TO POLICYHOLDER: ___Self ___Child ___Spouse ___Guardian ___Other

NAME OF POLICY HOLDER: _____ GENDER: ___M ___F
(If different from Responsible Party)
BIRTHDATE OF POLICYHOLDER: _____ PHONE NUMBER: _____

WHERE YOU REFERRED TO OUR PRACTICE? ___YES ___NO

REFERRING PHYSICIAN: _____ FRIEND: _____

PRIMARY CARE PHYSICIAN:

_____

REASON FOR VISIT: _____

*****REASON FOR VISIT:

_____

DO YOU HAVE ANY MEDICAL ALLERGIES?

____I HAVE NONE ___MEDICATION ALLERGIES: _____

LAST PNEUMONIA VACCINATION: _____ LAST FLU VACCINATION: _____

HISTORY OF CANCER: ___YES ___NO **AN Y FALLS WITHIN A YEAR: _____

WHAT MEDICATIONS ARE YOU CURRENTLY TAKING? (Use the back of this page if necessary)

NAME: _____ DOSE:_____FREQUENCY:_____

NAME: _____ DOSE:_____FREQUENCY:_____

NAME: _____ DOSE:_____FREQUENCY:_____

NAME: _____ DOSE:_____FREQUENCY:_____

NAME: _____ DOSE:_____FREQUENCY:_____

NAME: _____ DOSE:_____FREQUENCY:_____

NAME: _____ DOSE:_____FREQUENCY:_____

PAST SURGERIES:

PROCEDURE: DATE:

FAMILY LIFE:

____SINGLE____MARRIED ____WIDOWED____ SEPARATED____ DIVORCED ____

TOBACCO USE:

____ I DO NOT USE TOBACCO ____ I SMOKE TOBACCO PRODUCTS HOW MUCH_____

ALCOHOL CONSUMPTION:

____I DO NOT DRINK ALCOHOL ____I HAVE A HISTORY OF ALCOHOL ABUSE
____I DRINK LESS THAN 3 DRINKS OF ALCOHOL WEEKLY
____I DRINK 3 OR MORE DRINKS OF ALCOHOL WEEKLY
____I DRINK 2 OR MORE DRINKS DAILY

FAMILY HISTORY:

	YOUR SELF	OTHER FAMILY MEMBERS
CANCER	____YES ___NO	_____
HIGH BLOOD PRESSURE	____YES ___NO	_____
HEART PROBLEMS	____YES ___NO	_____
HEPATITIS	____YES___NO	_____
BLEEDING PROBLEM	____YES ___NO	_____
DIABETES	____YES ___NO	_____
SEIZURES	____yes ___NO	_____
ASTHMA	____YES ___NO	_____

***UNUSUAL REACTION TO ANESTHESIA?

_____

PLEASE READ AND SIGN

I HEREBY AUTHORIZE MY INSURANCE BENEFITS TO BE PAID DIRECTLY TO DR. LESLIE A. HESS. I UNDERSTAND I AM RESPONSIBLE FOR ALL CHARGES INCLUDING ANY COSTS INCURRED DUE TO ANY EFFORT TO COLLECT FOR SERVICES RENDERED. I REALIZE I AM RESPONSIBLE TO PAY FOR NON-COVERED SERVICES AND I HEREBY AUTHORIZE THE RELASE OF PERTINENT MEDICAL INFORMATION TO MY INSURANCE CARRIERS.

SIGNATURE: _____DATE:_____

PATIENT HIPPA NOTICE OF PRIVACY ACKNOWLEDGEMENT

I, _____ (NAME) ACKNOWLEDGE RECEIVING

ON_____ (DATE) A COPY OF THE HESS ANKLE & FOOT CENTER HIPPA NOTICE

OF PRIVACY PRACTICES.

PATIENT
SIGNATURE:_____DATE:_____