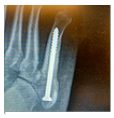


Carriero Foot and Ankle, Inc
Foot and Ankle Surgery

310 Santa Fe Dr. Ste. 112, Encinitas, CA 92024
Phone: (760) 642-7009 • Fax: (760) 230-1453
carrierofootandankle.com

Patient Medical Form

Patient Name: _____ DOB: _____

Are you: ☐ Right-handed ☐ Left-handed

Height: _____ Weight: _____ Shoe Size: _____

Date of injury / onset of problem: _____

Is this work related? ☐ Yes ☐ No

Orthopedic Problems / Symptoms (choose one): ☐ Right ☐ Left

_____

_____

Condition caused by: _____

Brief explanation of injury: _____

_____

_____

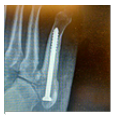
_____

What treatment have you had thus far? _____

_____

_____

_____



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Patient Name: _____ DOB: _____

OB/GYN for WOMEN: Are you pregnant now? ☐ Yes ☐ No

Do you have any allergies? ☐ Yes ☐ No

Current Medications

Please list any known drug, food, environmental allergies below: ☐ **List attached**

Medication	Dose	How Often?

Past Medical History

Arthritis	◯ No	◯ Yes
Asthma	◯ No	◯ Yes
Cancer	◯ No	◯ Yes
Diabetes (select type): Select type	◯ No	◯ Yes
Emphysema	◯ No	◯ Yes
Heart Disease or any heart condition	◯ No	◯ Yes
Hepatitis	◯ No	◯ Yes
Hypertension	◯ No	◯ Yes
Kidney Disease	◯ No	◯ Yes
Osteoporosis	◯ No	◯ Yes
Peptic Ulcers	◯ No	◯ Yes
Stroke	◯ No	◯ Yes
Thyroid Problems	◯ No	◯ Yes

Family Medical History

Arthritis	◯ No	◯ Yes
Asthma	◯ No	◯ Yes
Cancer	◯ No	◯ Yes
Diabetes	◯ No	◯ Yes
Emphysema	◯ No	◯ Yes
Heart Disease or any heart condition	◯ No	◯ Yes
Hepatitis	◯ No	◯ Yes
Hypertension	◯ No	◯ Yes
Kidney Disease	◯ No	◯ Yes
Osteoporosis	◯ No	◯ Yes
Peptic Ulcers	◯ No	◯ Yes
Stroke	◯ No	◯ Yes
Thyroid Problems	◯ No	◯ Yes

Social History

What is your smoking history?

☐ Never smoked ☐ Former smoker

☐ Current smoker – how many per day? _____

What is your alcohol intake?

☐ I do not drink ☐ I drink occasionally

☐ I drink daily ☐ Former alcohol drinker

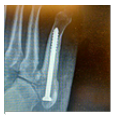
Which best describes your living situation?

☐ Living alone ☐ Living with family ☐ Living with friends ☐ Other

Past Surgical Procedures

List any surgical procedures you've had and your approximate age at the time: ☐ **List attached**

Procedure	Age



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Review of Systems

Constitutional		
Significant Weight Change	○ Yes	○ No
Fever/Chills	○ Yes	○ No
Fatigue	○ Yes	○ No
Feeling Tired or Poorly	○ Yes	○ No

Cardiovascular		
Chest Pain	○ Yes	○ No
Rapid or Irregular Heartbeat (Palpitations)	○ Yes	○ No
Leg pain with Exercise (Leg Claudication)	○ Yes	○ No
Slow Heartrate	○ Yes	○ No
Leg Swelling	○ Yes	○ No

Respiratory		
Cough	○ Yes	○ No
Wheezing	○ Yes	○ No
Chest Tightness	○ Yes	○ No
Pain with Respiration	○ Yes	○ No
Shortness of Breath	○ Yes	○ No

Gastrointestinal		
Abdominal Pain	○ Yes	○ No
Vomiting	○ Yes	○ No
Constipation	○ Yes	○ No
Diarrhea	○ Yes	○ No
Heartburn	○ Yes	○ No
Black Stool	○ Yes	○ No

Heme/Lymph		
Easy Bleeding	○ Yes	○ No
Easy Bruising	○ Yes	○ No
Swollen Glands	○ Yes	○ No

Neurological		
Convulsions	○ Yes	○ No
Confused/Disoriented	○ Yes	○ No
Fainting (Syncope)	○ Yes	○ No
Coordinating/Balance Problems	○ Yes	○ No
Weakness	○ Yes	○ No
Dizziness (Vertigo)	○ Yes	○ No

Musculoskeletal		
Leg Pain	○ Yes	○ No
Localized joint stiffness	○ Yes	○ No
Localized joint pain	○ Yes	○ No
Soft Tissue Swelling	○ Yes	○ No
Joint Swelling	○ Yes	○ No
Muscle Aches (Myalgia's)	○ Yes	○ No

List any other medical conditions that you may have:

_____

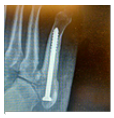
_____

_____

_____

Primary Care Physician: _____ Referring Physician: _____

Name of Pharmacy: _____ Pharmacy Phone: _____



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Patient Name: _____ DOB: _____

HIPAA Authorization for Use or Disclosure of Health Information

I authorize **Carriero Foot and Ankle, Inc.** to leave messages with medical information on voicemail/text/answering machine/e-mail at: (please indicate below) **Please note that if you contact us in any form you did not check and request a response back via that same method, you are then authorizing us to use that method at that time.

☐ Home Phone ☐ Cell Phone ☐ Work phone ☐ E-mail

Please check here if you authorize us to send you Patient Portal Log in Credentials to the email provided. ☐ Yes ☐ No

I authorize for the following individual(s) to receive information pertaining to any medical history or treatment received:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

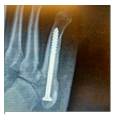
In accordance with Privacy Rule of the Health Insurance Portability and Accountability Act (HIPAA) of 1996, I understand that:

a. I may revoke this authorization at any time, except to the extent where action has already been taken in accordance to the original authorization for disclosure. My revocation must be in writing, signed by me or on my behalf, and delivered to our office at **310 Santa Fe Drive, #112, Encinitas, CA 92024**. My revocation will be effective once received by Carriero Foot and Ankle, Inc.
b. The information provided under the release may be subject to re-disclosure by the recipient under circumstances no longer protected by HIPAA Privacy Rules.
c. My authorized representative will be required to provide legal documents to prove their authority to sign on my behalf and may be required to provide proof of identity.
d. A copy of this authorization may be used with the same effectiveness as the original.

This authorization shall supersede any prior written authorization I have made regarding the use, release, and disclosure of my medical information. This authorization will expire 2 years from the date it is signed.

Patient/Authorized Representative Signature (Relationship): _____ Date: _____

Date Updated with Initials: _____



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Patient Name: _____ DOB: _____

HIPAA Notice of Privacy Practices

Privacy Officer: Yessica Ramirez, (760) 642-7009
I hereby acknowledge that I have the right to a copy of the medical practice's Notice of Privacy Practices. I further acknowledge that a copy of the current notice and a copy of any amended Notice of Privacy practices will be available in the reception area and on our website at all times.

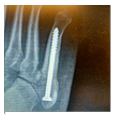
AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form: In accordance with State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

- Carriero Foot and Ankle Inc., uses SureScripts, Inc., a prescription system that allows prescriptions and related information to be exchanged between my providers and the pharmacy. The information sent between these systems may include details of any and all prescription drugs I am currently taking and/or have taken in the past.
- This authorization may include disclosure of prescription information related to alcohol and drug abuse, mental health treatment, and/or confidential HIV related information by SureScripts, Inc.
- I have the right to revoke this authorization at any time by writing. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
- Signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.
- Information disclosed under this authorization might be re-disclosed by the recipient, and this re-disclosure may no longer be protected by state or federal law.
- This authorization expires one year from the date of my signature below.
- THIS AUTHORIZATION DOES NOT AUTHORIZE Carriero Foot and Ankle Inc., TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAN THOSE PERMITTED UNDER APPLICABLE LAW.

Financial Agreement

In order to provide you with the highest quality of affordable healthcare, we request that our charges for office visits be paid at the conclusion of each visit. Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not substitute for payment. Some companies pay fixed allowances for certain procedures; others pay a percentage of the charge. It is your responsibility to pay any co-insurance, or any other balance not paid by your insurance. If this account is assign to an attorney for collection and/or suit, the prevailing party shall be entitled to reasonable attorney's fees and costs of collection, to the extent necessary to determine liability for payment and to obtain reimbursement. I authorize disclosure of the patient's records. I hereby assign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all medical and/or surgical benefits to include major medical benefits to which I'm entitled, including Medicare, private insurance, and other health plans to the provider. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am finically responsible for all charges whether or not pain by said insurance. I hereby authorize said assignee to release all necessary information to secure payment. Carriero Foot and Ankle, Inc. and/or physicians may have a financial or other interest in companies which manufacture or distribute some of the products that are used in the course of your treatment. If you have questions or concerns about a particular product or manufacturer, please let your physician know.

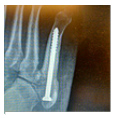
Notice to Patients About Open Payment Database

The Open Payments database is a federal tool used to search payments made by drug and device companies to physicians and teaching hospitals. It can be found at https://openpaymentsdata.cms.gov.

For informational purposes only, a link to the federal Centers for Medicare and Medicaid Services (CMS) Open Payments web page is provided here. The federal Physician Payments Sunshine Act requires that detailed information about payment and other payments of value worth over ten dollars ($10) from manufacturers of drugs, medical devices, and biologics to physicians and teaching hospitals be made available to the public.

Patient/Authorized Representative Signature (Relationship): _____ Date: _____

Date Updated with Initials: _____



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Patient Name: _____ DOB: _____

Age: _____ Sex: ☐ M ☐ F Last 4 SSN : _____

Home Address: _____
Street City State Zip

Home Phone: (____) _____ Cell (____) _____ Work (____) _____

Email: _____ Employer: _____ Occupation: _____

Preferred Method of Contact: ☐ Home ☐ Cell

Race: ☐ American Indian or Alaska native ☐ Asian ☐ Black or African American ☐ Decline
☐ Native Hawaiian or Pacific Islander ☐ White ☐ Other _____

Ethnicity: ☐ Non-Hispanic or Latino ☐ Hispanic or Latino ☐ Decline

Language: _____ ☐ Decline

Marital Status: ☐ Single ☐ Married ☐ Separated / Divorced ☐ Widowed

Insurance Information

Primary Insurance Co: _____ Relationship to Insured: _____

Subscriber's Name: _____ Subscriber's SSN: _____

Member ID #: _____ Group #: _____ DOB: _____

Secondary Insurance Co: _____ Relationship to Insured: _____

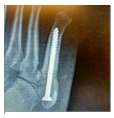
Subscriber's Name: _____ Subscriber's SSN: _____

Member ID #: _____ Group #: _____ DOB: _____

Emergency Contact Information

Name: _____ Relationship to patient: _____

Phone: (____) _____ Cell (____) _____ Work (____) _____



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NOTICE AND ACKNOWLEDGMENT OF RECEIPT AND UNDERSTANDING

NOTICE TO PATIENTS

Medical doctors are licensed and regulated by the Medical Board of California.

To check up on a license or to file a complaint go to
www.mbc.ca.gov,
email: licensecheck@mbc.ca.gov,
or call (800) 633-2322.

_____ _____
Date Patient's Name (Type or Print)

_____
Patient's Signature

_____ _____
Date Patient Representative's Name and Relationship (Type or Print)

_____
Patient's Representative's Signature