Patient Medical Forms

Patient Name: ____ **DOB:** ________________________

Age: ______ **Sex:** ☐ M ☐ F ☐ Other **Last 4 SSN :** __________________

Home Address: ____
Street City State Zip

Cell Phone: (_____) ______________________ **Work Phone:** (_____) ________________________

Email: _____________________________ **Employer:** _______________ **Occupation:** ____________

Preferred Method of Contact: ☐ Phone ☐ Email

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 ☐ Divorced ☐ Widowed

Primary Care Physician: ________________________ **Referring Physician:** _______________________

Name of Pharmacy & Address: ____

____

Pharmacy Phone: (_____)___________________________

Emergency Contact Information

Name: _________________________________ **Relationship to patient:** _______________________

Cell Phone: (_____) _____________________ **Work Phone:** (_____) _________________________

Patient Name: ______________________________ **DOB:** __________________

Height: ____________ **Weight:** ____________ **Shoe Size:** __________
(Podiatry patients only)

Are you: ☐ Right-handed ☐ Left-handed

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

Current Medical Concern

Date of injury/onset of problem: ________________

Is this work related? ☐ Yes ☐ No **Is this case in litigation?** ☐ Yes ☐ No

Orthopedic Problems/Symptoms: ☐ Right ☐ Left ☐ Bilateral **Body Part:** ___________

____

Condition caused by: ______________________________________

Brief explanation of injury: ______________________________________

____

What treatment/imaging have you had thus far? (PT, medications, cortisone shot, brace, MRI/X-ray, surgery, acupuncture, etc.):______________________________

____

Do you have any allergies? ☐ Yes ☐ No

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

Current Medications & Supplements

Medication/Supplement ☐ List attached	Dose	How Often?

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

____ Former alcohol drinker

____ I drink – how many drinks **per week**?____

Recreational Drugs: ____________________

Which best describes your living situation?

____ Living alone ____ Living with family ____ Living with friends ____ Other

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Past Surgical Procedures

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

Procedure	Date

Past Medical History

Arthritis	Yes	No
Asthma	Yes	No
Cancer	Yes	No
Diabetes: ☐ Type 1 ☐ Type 2	Yes	No
Emphysema	Yes	No
Heart Disease or any heart condition	Yes	No
Hepatitis	Yes	No
Hypertension	Yes	No
Kidney Disease	Yes	No
Osteoporosis	Yes	No
Peptic Ulcers	Yes	No
Stroke	Yes	No
Thyroid Problems	Yes	No

Family Medical History

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

List any other medical conditions that you have: ______________________________

____

____

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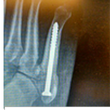
Review of Systems

Constitutional		
Significant Weight Change	Yes	No
Fever	Yes	No
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
Limb Weakness	Yes	No
Dizziness (Vertigo)	Yes	No
Musculoskeletal		
Leg Pain	Yes	No
Arm 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)/Muscle pain	Yes	No



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 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/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 ☐ E-mail

Please check here if you authorize us to send you Patient Portal Login 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:

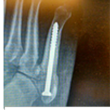
a. I may revoke this authorization at any time, except to the extent where action has already been taken in accordance to the original authorization for disclosure. My revocation must be in writing, signed by me or on my behalf, and delivered to our office at **310 Santa Fe Drive, #112, Encinitas, CA 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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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

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

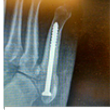
The Open Payments database is a federal tool used to search payments made by drug and device companies to physicians and teaching hospitals. It can be found at https://openpaymentsdata.cms.gov.

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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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