Patient Full Name: _____ **DOB:** _____

Sex: [ ]Male [ ]Female [ ]Other **Language:**_____ [ ]Decline **Last 4 SSN:** _____

Home Address: _____

Preferred Contact: [ ]Phone [ ] Email **Home /Cell Phone:** _____

Email Address: _____**Occupation:** _____

Race: [ ]American Indian / Alaska Native [ ]Asian [ ]Black / African American

[ ]Native Hawaiian / Pacific Islander [ ]White [ ]Other: _____ [ ]Decline to State

Ethnicity: [ ] Non-Hispanic or Latino [ ] Hispanic or Latino [ ] Decline

Marital Status: [ ] Single [ ] Married [ ] Divorced [ ] Widowed [ ] Separated

Primary Care Physician: _____**Referring Physician:** _____

Pharmacy Name: _____**Pharmacy Phone:** _____

Emergency Contact/Relationship: _____ **Phone:** _____

HIPAA Authorization- I authorize **Carriero Foot and Ankle, Inc**. to leave messages with medical information on voicemail/answering machine/e-mail at the checked methods below. Note: If you contact us via a format not checked, you authorize us to reply via that same method.

[ ]Home Phone [ ]Cell Phone [ ]E-mail Authorization to send Patient Portal Email? [ ]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.

HIPAA Notice of Privacy Practices- Privacy Officer: Yessica Urbina, (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.

Patient / Guardian Signature: _____**Date:** _____

CLINICAL INTAKE & CURRENT CONCERN

Patient Name: _____ **DOB:** _____

Height: _____ **Weight:** _____ Dominant **Hand:** [ ]Right [ ]Left

Shoe Size:_____ **Females: Are you pregnant now?** [ ]Yes [ ]No

Living situation: [ ] Alone [ ] Family [ ] Friends [ ] Other_____
Date of Injury/Onset: _____**Work Related?** [ ]Yes [ ]No **In Litigation?** [ ]Yes [ ]No

Orthopedic Symptoms: [ ]Right [ ]Left [ ]Bilateral **Affected Body Part:** _____

Brief Explanation of Injury and/or Symptoms: [ ]Unknown

_____
_____

Prior Treatments or Imaging Done So Far: [ ]None

_____
_____

Any known drug, food, or environmental allergies? [ ] No [ ]Yes, List allergies below:

_____
_____

Current Medications & Supplements: [ ]None [ ]List Attached

_____
_____
_____

Past Surgical Procedures and Dates[ ]Not Applicable [ ] List Attached

1._____
2._____
3._____
4._____

REVIEW OF SYSTEMS: Check if applicable / [ ]None Applicable

1. Constitutional
[ ] Significant Weight Change
[ ] Fever / Chills
[ ] Fatigue
[ ] Feeling Tired or Poorly

2. Cardiovascular
[ ] Chest Pain
[ ] Rapid /Irregular Heartbeat (Palpitations)
[ ] Leg Pain with Exercise
[ ] Slow Heartrate
[ ] Leg Swelling

3. Respiratory
[ ] Cough
[ ] Wheezing
[ ] Chest Tightness
[ ] Pain with Respiration
[ ] Shortness of Breath

4. Gastrointestinal
[ ] Abdominal Pain
[ ] Vomiting
[ ] Constipation
[ ] Diarrhea
[ ] Heartburn
[ ] Black Stool

5. Heme/Lymph
[ ] Easy Bleeding
[ ] Easy Bruising
[ ] Swollen Glands

6. Neurological
[ ] Convulsions
[ ] Confused / Disoriented
[ ] Fainting (Syncope)
[ ] Coordinating/Balance Problems
[ ] Limb Weakness
[ ] Dizziness (Vertigo)

7. Musculoskeletal
[ ] Arm Pain
[ ] Localized Joint Stiffness
[ ] Localized Joint Pain
[ ] Soft Tissue Swelling
[ ] Joint Swelling
[ ] Muscle Aches (Myalgia's)/ Pain
[ ] Leg Pain

Patient Name: _____ **DOB:** _____

Patients 60 years or older: Do you feel unsteady when standing or walking? [ ]Yes [ ] No
Do you worry about falling? [ ]Yes [ ] No **Have you fallen in past year?** [ ]Yes [ ] No

If yes: How many times did you fall? _____ **Injured?** [ ]Yes [ ] No

Personal History, circle any that apply: [ ]None Applicable

Arthritis Asthma Cancer Diabetes Type 1 Diabetes Type 2 Emphysema

Heart Disease / Condition Hepatitis Hypertension (High BP) Kidney Disease Osteoporosis

Pacemaker Peptic Ulcers Stroke Thyroid Problems

Family History, circle any that apply: [ ]None Applicable

Arthritis Asthma Cancer Diabetes Type 1 Diabetes Type 2 Emphysema

Heart Disease / Condition Hepatitis Hypertension (High BP) Kidney Disease Osteoporosis

Pacemaker Peptic Ulcers Stroke Thyroid Problems

List any other medical conditions that you have:

_____

_____

SOCIAL HISTORY & CLINICAL SCREENINGS

Do you or have you ever smoked tobacco? [ ]Never

[ ]Current every day- **# years** _____ [ ]Current some days smoker-**# years** _____

[ ]1 pack/week [ ]2 packs/ week [ ]1/4 pack/day [ ]1/2 pack/day [ ]1 pack/day [ ]2 packs/day
[ ]3 or more packs/day **Date of your most recent tobacco screening:** _____

Has tobacco cessation counseling been provided? [ ]Yes, Date: : _____ [ ] No

[ ]Former- **When did you quit?**[ ]1-5 years [ ]6-10 years [ ]11-15 years [ ] 16+ years

Do you or have you ever used any other forms of tobacco or nicotine? [ ]Yes [ ] No

Do you or have you used e-cigarettes/vape? [ ]Never used [ ]Former user [ ]Current user

Do you or have you ever used smokeless tobacco? [ ] Never

[ ] Former [ ] Current snuff user [ ] Currently chews [ ] Currently use moist powdered tobacco

Do you or have you ever used any illicit or recreational drugs? [ ] Yes [ ] No

What is your level of alcohol Consumption? [ ] None [ ] Occasional [ ] Moderate [ ] Heavy

How many times per week do you consume alcohol? [ ]Less than 1 time/week
[ ] 1-2 times / week [ ] 3-4 times / week [ ] 5-7 times/ week
Females: How many days in the past year have you consumed 4 or more drinks? _____
Males: How many days in the past year have you consumed 5 or more drinks? _____

Patient Name: _____ **DOB:** _____

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

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 / Guardian Signature: _____ **Date:** _____