2020 Annual Update

For office use only

ACCT #:_______________

Patient Name: ____ Date of Birth: _________ Age: _____
Last First MI

Social Security No: ______________________ Gender: Male/ Female Marital Status: Single/Married/Divorced/Widow
Circle One Circle One

Address: ____
Street City State Zip

Phone Numbers: ____
Home Mobile Work

Email Address: ____ Spouse's Name: ___________________________

Pharmacy: ____ Pharmacy Phone: _________________________

Employer: ____ Title/Job: ________________________________

Primary Care Doctor: ____ Phone: _________________________________

Emergency Contact: ____ Phone: _________________________________

PLEASE INCLUDE A COPY OF A PHOTO ID AND ALL INSURANCE CARDS

Primary Insurance Name: ____
Policy/Contract #: ____Group #: ___________________________
Name of Policy Holder: ____________________________________Policy Holder DOB:__________________
Relationship to Patient: _____________________ Policy Holder SSN: _________________________________

Secondary Insurance Name: ____
Policy/Contract #: ____Group #: ___________________________
Name of Policy Holder:_____________________________________ Policy Holder DOB:__________________
Relationship to Patient: _____________________ Policy Holder SSN: _________________________________

Other Insurance Coverage (Auto/Worker's Compensation)

Name of Company: ____
Policy/Contract #: ____Group #: ___________________________
Name of Policy Holder:_____________________________________ Policy Holder DOB:__________________
Relationship to Patient: _____________________ Policy Holder SSN: _________________________________
Claim #: ___________________________
Adjustor: _____________________________________ Phone: ____
Case Manager: _________________________________ Phone: ____

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Foot and Ankle Reconstruction Center of Georgia

List or attach a complete list of all CURRENT MEDICATIONS (Include how much and how often taken), including vitamins/supplements:

Allergies: (circle) NONE /Narcotics/NSAIDS/Penicillin / Sulfa / Aspirin / Contrast / Latex / Iodine / Shellfish / Tape
Gluten Intolerance / Food Allergies / Metal / Other: ____

PAST MEDICAL HISTORY (circle all that apply) *NONE*

Cancer: lung skin breast cervical prostate
Neurological: stroke neuropathy vertigo seizures migraines
Skin: eczema psoriasis ulcers vitiligo dermatitis hives
Psychiatric: bipolar depression anxiety claustrophobia dementia
Respiratory: emphysema asthma shortness of breath COPD
Eyes/Ears/Noses/Mouth and Throat: cataracts glaucoma hearing loss
Genitourinary: STD HIV UTI kidney stones kidney/bladder infections kidney disease
Hematologic/Immunologic: dialysis anemia sickle cell bleeding disorder
Gastrointestinal: stomach ulcers hernia hepatitis reflux/GERD gallbladder disease
Cardiovascular: heart attack coronary disease high blood pressure irregular heart rhythm peripheral vascular disease
Musculoskeletal: lupus osteoarthritis rheumatoid arthritis fibromyalgia gout back pain
Metabolic: hypoglycemia diabetes hypothyroidism hyperthyroidism hyperlipidemia osteoporosis

Other: ____

PAST SURGERIES AND HOSPITALIZATIONS (circle all that apply) *NONE*

Tonsils/Adenoids Amputations Other Vascular Bypass Appendix
Gallbladder Hysterectomy Hernia Angioplasty
Coronary/Heart Bypass

Other: ____

SOCIAL HISTORY

Height: ___________________ Weight: ___________________ Shoe Size: ________________________

Do you currently use illicit drugs (pain pills, marijuana, cocaine etc.)? YES/NO

Do you have a history of alcohol or drug abuse including prescription medications? YES/NO

Have you have ever used tobacco? YES/NO If yes, amount per day________ Age began: ________ Age quit: _________

Do you ever drink alcohol? YES/NO If yes, How often: _____________________How much: ______________________

Is there a **family history** of any specific medical conditions or diseases? ____

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REVIEW OF SYSTEMS: (circle any symptom that you have had in the last 6 month) *NONE*

Neurological: frequent headache limb weakness limb numbness dizziness tremors rigidity balance issues
Skin: rashes/hives skin discoloration lesions ulcers itching nail problems easy bruising unusual hair loss
Respiratory: persistent cough shortness of breath wheezing can't breathe lying flat coughing up blood
Eyes/Ears/Noses/Mouth and Throat: sore throat stiff neck nose bleeds hearing loss ringing in the ears
Gastrointestinal: nausea/vomiting difficulty swallowing abdominal pain heartburn/indigestion
Cardiovascular: palpitation irregular heartbeat exercise intolerance leg swelling leg pain when walking
Musculoskeletal: joint pain/stiffness joint swelling muscle weakness back pain muscle spasms falling
Constitutional/Endocrine: fever chills weakness/fatigue weight loss weight gain insomnia snoring excessive thirst excessive urination cold or heat intolerance

Other: ____

To the best of my knowledge, I have answered the questions on this form as accurately as possible. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor and staff of any changes in my medical status. I, the undersigned or as parent, legal guardian or power of attorney of the undersigned hereby authorize the physicians and their assistants of the Foot and Ankle Reconstruction Center of Georgia to administer treatment as deemed necessary to myself or the patient below for whom I am responsible.

____

Print Name of Patient

____

Signature of Patient/Parent/Guardian/Power of Attorney

____

Date