Welcome to...

HAYCOCK Foot & Ankle Center

Patient's Name: _____

Phone Number: _____
Cell Phone: _____
Address: _____
City: _____ State: _____ Zip: _____
Age: _____ Date of Birth: _____
Email Address: _____
Social Security Number: _____
Height: _____ **Weight**: _____ **Shoe Size**: _____

Primary Place of Employment of Patient **or** Parent of Child
Place of Employment: _____
Address of Employer: _____
City: _____ State: _____ Zip: _____
Phone Number of Employer: _____

Name of Spouse /Parent/Legal Guardian/Significant other:

_____
Phone Number: _____
Cell Phone: _____
Address: _____
City: _____ State: _____ Zip: _____

Emergency Contact Information: ***Name other than listed above***
Name: _____ Relationship: _____
Phone Number: _____
Cell Phone: _____
Address: _____
City: _____ State: _____ Zip: _____

If this is a divorced or separated home, name of custodial residential parent on document: _____
County and state where document is filed: _____
If not living with person of legal custody, state name of person with whom child is living.
Name: _____ Relationship: _____
Phone Number: _____
Cell Phone: _____

Contact Preferences : Check all that apply
Email ___ Mail ___ Phone ___ Ok to leave message:
___ on answering machine ____ with person who answers phone

Primary Insurance
Insurance Company Name: _____
Policy Holder's Name: _____
Policy Holder's Date of Birth: _____

Secondary Insurance
Insurance Company Name: _____
Policy Holder's Name: _____
Policy Holder's Date of Birth: _____

Additional Insurance
Insurance Company Name: _____
Policy Holder's Name: _____

Family Physician Name: _____
Phone # _____
City: _____ Date Last Seen: _____
Do you see a Cardiologist/Heart doctor: **YES or NO**
List Names of Additional Doctors Currently Seeing:
_____
_____

Please pick one from each section in bold

Race: ___ American Indian or Alaska Native ___ Asian
___ Black or African American ____ Other
___ Native Hawaiian or Other Pacific Islander ___ White

Ethnicity: ___ Hispanic or Latino OR ___ Not Hispanic or Latino

Primary Language: _____

Pharmacy Information
Please list at least one local pharmacy for short term medication
Primary Pharmacy : _____
Street Name: _____
City: _____
Secondary Pharmacy : _____
Street Name: _____
City: _____

Workers Compensation
Is this a work related Injury? _____
Will you be filing this with Worker's Compensation? _____
Date of Injury: _____ Claim Number: _____

May release medical information to Name: _____ Relationship: _____ Date: _____
Name: _____ Relationship: _____ Date: _____
It is patient's responsibility to call if medical release recipients change.

Thank you for choosing Haycock Foot & Ankle Center
2311 Baton Rouge Ave, Lima Ohio 45805 419 228 3338

HAYCOCK Foot & Ankle Center

Acknowledgement of Receipt of Notice of Privacy Practices (HIPAA)

I, _____, acknowledge and agree that I have received

(Print name of patient)

a copy of *Haycock Foot & Ankle Center's* notice of privacy policy.

_____ _____

Signature of Patient /Parent if patient is under 18/ Legal Guardian Date

_____ _____

Print name of Parent if patient is under 18/ Legal Guardian Relationship to patient

HAYCOCK Foot & Ankle Center

Acknowledgement of Receipt of Notice of Financial Policy

I, _____, acknowledge I have read and received a copy of

(Print name of patient)

Haycock Foot & Ankle Center's financial policy and understand

my financial responsibility and agree to the terms within the Financial Policy .

_____ _____

Signature of Patient /Parent if patient is under 18/ Legal Guardian Date

All professional services rendered are charged to the patient. The patient is responsible for fees regardless of insurance coverage or litigation. It is customary to pay for the services when rendered unless other arrangements have been made in advance. If we are a participating provider with your insurance company you are expected to pay your co-pay at the time of service.

I hereby authorize Haycock Foot & Ankle Center to furnish information to my insurance carrier concerning my illness and treatments and I hereby assign to the physician (s) all payments for my medical services rendered to myself or dependents. I understand that I am responsible for any amount not covered by my insurance. I hereby give consent to use my/child's photography for security purposes. I understand the picture will be retained in their medical record and used for identification purposes only. I certify that the information in this questionnaire is true and correct to the best of my knowledge. I give my permission to the doctor to administer and perform such procedures as may be deemed necessary in the diagnosis and/or treatment of my feet.

_____ _____

Signature of Patient /Parent if patient is under 18/ Legal Guardian Date

Patient's Name: _____

Chief Complaint

What is the reason you are here? _____

How long have you had it? _____ What started it or made it worse? _____

What makes it feel better? _____

What treatment have you had? _____

Have you ever been treated by another podiatrist? Yes / No If so, for what condition and when? _____

Have you ever seen Dr. Haycock before? Yes / No If yes, Was it within the last three years? Yes / No

Allergies *circle either* Yes OR No *(Then circle or list what applies If you circled yes)*

Adhesive Tape	Anesthetics	Anticoagulant Therapy	Bactrim	Codeine	Demerol
Iodine	Latex	Morphine	Novocain	Penicillin	Sea Foods
Sulfa	X-Ray Dye	List Others in empty spaces			

Medications List (List medications you are currently taking in space below or give a medication list to the receptionist)

Name of Medication	Dosage	Frequency	Reason taking

Review of Symptoms (Please *circle* whatever condition applies, list in other or circle *None*)

Currently Pregnant
Immune System Problems
Excessive Fatigue
Frequent Headaches
Weight Gain
Weight Loss, Unintentional

Blurred Vision
Eye Problems
Loss of Vision

Hearing Problems
Sinus Problems

Blisters
Dry, Scaly Skin
Itching
Skin Related Symptoms
Skin Sores
Thick Scars

Ankle Pain
Back Pain
Foot or Leg Cramps
Foot Pain
Heel Pain
Joint Pain or Stiffness

Joint Swelling
Leg Pain
Muscle Weakness
Stiffness in Morning
Tired Feet

ADD/ADHD
Balance Problems
Dizziness
Fainting
Neurological Problems
Numbness
Tingling

Painful Urination
Inability to Urinate
Blood in Urine
Decreased Urination
Kidney Problems

Blood Sugar Low/High
Diabetes
Frequent Thirst
Hair loss
Poor Healing
Thyroid Problems

Breathing Difficulties
Excessive Coughing
Shortness of Breath
Sinus Problems
Wheezing

Constipation
Diarrhea
Digestive Problems
Heartburn
Loss of Appetite
Nausea
Special Diet
Stomach Problems

Chest Pains
Cholesterol Levels
Circulatory Problems
Cold Feet
Heart Palpations
Heart Problems
Swelling in Ankles/Legs
Swelling in Feet

Blood Clotting Problems
Bleeding Problems
Calf Pain

Night Sweats
Swollen Lymph Nodes

Anxious Feelings
Depression
Nervous Problems
Substance Abuse

Other (problems or symptoms not listed above): _____

None

Medical History (Please *circle* whatever condition applies, list in other or circle *None*)

AIDS/HIV
Anemia
Angina
Anxiety Disorders
Arthritis
Artificial Heart Valves
Artificial Joints _____
Asthma
Back Problems
Blood Clots
Cancer _____
Circulatory Problems
Congestive Heart Failure
COPD (Lung Disease)
Depression
Diabetes
DVT
Epilepsy
Gout
Glaucoma
Gynecological Problems
Heart Disease _____
Hemophilia
Hepatitis
High Blood Pressure
Jaundice/Yellow Skin
Kidney Disease
Liver Disease
Low Blood Pressure
Malignant Hypothermia
Pacemaker
Phlebitis
Psychiatric History _____
Radiation Treatment
Reaction to Metal
Respiratory Disease
Rheumatic Fever
Seizures
Stomach Ulcers
Stroke
Tuberculosis
Ulcers Feet
Ulcers Other
Varicose Veins
Venereal Disease

Others list: _____

None

Surgical History (Please *circle* whatever condition applies, list in other or circle *None*.)

Amputation of Digit	Bowel Surgery	Gall Bladder Removed	Joint Replacement _____	Sinus Surgery	Foot Surgery _____
Amputation Partial Foot	Breast Surgery R / L	Hammertoe Surgery	Kidney Surgery	Stomach Surgery	_____
Amputation Total Foot	Bunionectomy R / L	Head Surgery	Knee Surgery R / L	Tonsil/Adenoidectomy	_____
Angioplasty	Cardiac/Heart Surgery	Hemorrhoid	Nail Removal	Tubal Ligation	Other:_____
Ankle Surgery R / L	Colon/Intestinal	Hernia Surgery	Oral Surgery	Vasectomy	_____
Appendectomy	Ear Surgery R / L	Hip Surgery R / L	Pace Maker Insertion	Vein Stripping	_____
Back Surgery	Eye Surgery R / L	Hysterectomy	Shoulder Repair	Cancer Surgery _____	***None***

Social History (Please *circle an answer in each section and fill in where needed*)

Employment Status: *(circle All that Apply)* Full-Time Employment Unemployed Self Employed Disabled Child
Currently Off Work (Post-Op) Part Time Employment Retired Homemaker Temporarily Disabled Student
Occupation: (Current/ Former): _____

Alcohol Use:	***Illegal Drug Use:***	***Marital Status:***	***Regular Exercise:***	***Tobacco Use:***
None	Never Have Used	Single	Never	Never Have Used
Social	I *Currently* use:	Married	1-3 times/week	Cigarettes packs/day _____
Occasionally	_____	Separated	4 or more times/week	Other: _____
Daily	How Often:_____	Divorced	Describe:	Smokeless: _____
Weekly	In the *Past* I have used:	Widowed	_____	How Often:_____
Monthly	_____	Living w/ Someone	_____	No Longer Use
Recovering Alcoholic	How Often:_____	Engaged		Date Quit:_____

Live with: Husband, Wife, Mother, Father, Brother, Sister, Other, Alone ,Children ***How many Children do you have:*** _____
Do you Drink Caffeinated Beverages: Yes or No ***Cola, Tea, Coffee, Energy Drink*** ***If yes How many per day:*** _____
Immunization Status Up to Date (check One) ____ **Yes** ____ **No** *Last Tetanus Booster Date:*_____ *or* ***UNKNOWN***

Family History Hereditary Diseases (**circle all that applies** and to whom - mother father, etc) Or circle **NONE** or **UNKNOWN**

ADHD	__Mother __ Father __ Brother __ Sister __Son __ Daughter	Glaucoma	__Mother __ Father __ Brother __ Sister __Son __ Daughter
Arteriosclerosis	__Mother __ Father __ Brother __ Sister __Son __ Daughter	Gout	__Mother __ Father __ Brother __ Sister __Son __ Daughter
Autism	__Mother __ Father __ Brother __ Sister __Son __ Daughter	Heart Problems	__Mother __ Father __ Brother __ Sister __Son __ Daughter
Cancer	__Mother __ Father __ Brother __ Sister __Son __ Daughter	High Blood Pressure	__Mother __ Father __ Brother __ Sister __Son __ Daughter
COPD	__Mother __ Father __ Brother __ Sister __Son __ Daughter	Lung Disease	__Mother __ Father __ Brother __ Sister __Son __ Daughter
Dementia	__Mother __ Father __ Brother __ Sister __Son __ Daughter	Parkinson's	__Mother __ Father __ Brother __ Sister __Son __ Daughter
Diabetes	__Mother __ Father __ Brother __ Sister __Son __ Daughter	Psoriasis	__Mother __ Father __ Brother __ Sister __Son __ Daughter
Eczema	__Mother __ Father __ Brother __ Sister __Son __ Daughter	Renal Disease	__Mother __ Father __ Brother __ Sister __Son __ Daughter
Emphysema	__Mother __ Father __ Brother __ Sister __Son __ Daughter	Rheumatoid Arthritis	__Mother __ Father __ Brother __ Sister __Son __ Daughter
Familial Tremors	__Mother __ Father __ Brother __ Sister __Son __ Daughter	Stroke	__Mother __ Father __ Brother __ Sister __Son __ Daughter
Foot Problems	__Mother __ Father __ Brother __ Sister __Son __ Daughter	Tarsal Tunnel	__Mother __ Father __ Brother __ Sister __Son __ Daughter
Genetic Disease	__Mother __ Father __ Brother __ Sister __Son __ Daughter	Other _____	__Mother __ Father __ Brother __ Sister __Son __ Daughter