

# High Point Foot Center



## Patient Information Sheet

Last Name: \_\_\_\_\_ First Name/MI: \_\_\_\_\_

Street \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone: ( ) \_\_\_\_\_ - \_\_\_\_\_ Cell: ( ) \_\_\_\_\_ - \_\_\_\_\_ Is Cell Phone Primary Number Y N

Email Address: \_\_\_\_\_

Social Security #: \_\_\_\_\_

Sex: M F Birthdate: \_\_\_\_\_ Marital Status: Single \_\_\_\_\_ Married \_\_\_\_\_ Widowed \_\_\_\_\_ Other \_\_\_\_\_

Race: \_\_\_\_\_ Ethnicity: Hispanic or Latino/ Non Hispanic or Latino Primary Language: \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Work Phone: ( ) \_\_\_\_\_ - \_\_\_\_\_

Spouse Name: \_\_\_\_\_ Birthdate: \_\_\_\_\_

In Case of Emergency Contact: \_\_\_\_\_ Phone: ( ) \_\_\_\_\_ - \_\_\_\_\_

Financial Responsible Party ( If Other Than Patient): Wife Husband Parent Other

Last Name: \_\_\_\_\_ First Name/ MI: \_\_\_\_\_

Street: \_\_\_\_\_ City/State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: ( ) \_\_\_\_\_ - \_\_\_\_\_ Birthdate: \_\_\_\_\_

How did you hear about our office? Newspaper \_\_\_\_\_ Internet \_\_\_\_\_ Yellow Pages \_\_\_\_\_ Other \_\_\_\_\_

I authorize the release of any medical information necessary to process any claim and chart notes sent to your primary Doctor as requested. I authorize payment benefits either to myself or to Dr. Henry as agreed upon at the time of treatment for services rendered. I understand I am liable for any deductibles, copays or non-covered services. I also verify I have provided High Point Foot Center with my correct insurance information. If it is incorrect, I will be responsible for the full monetary amount of all my services. This authorization shall be valid unless rescinded by one at a later date.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

If the patient is a minor (under 18 years of age) or is otherwise unable to sign on their own behalf, the patient representative who completed these forms should complete the following information:

\_\_\_\_\_  
Patient Representative Name

\_\_\_\_\_  
Signature

Relationship to Patient: \_\_\_\_\_

**ALL COPAYMENTS ARE DUE AT THE TIME OF SERVICE**



## Patient Health History

Patient Name \_\_\_\_\_ DOB \_\_\_\_\_

Is your problem today work, or accident related?      Y      N

Are you Currently Pregnant?      Y      N

### REVIEW OF MEDICAL CONDITONS:

PLEASE CHECK ALL THAT APPLY

#### HEENT

- ☐ None
- ☐ Glaucoma
- ☐ Sore Throat/ Difficulty Swallowing
- ☐ Dizziness
- ☐ Nose Bleeds
- ☐ Hearing Loss or Ringing
- ☐ Sinus Problems

Other \_\_\_\_\_

#### MUSCULOSKELETAL

- ☐ None
- ☐ Gout
- ☐ Muscle Pain or Cramps
- ☐ Osteoarthritis
- ☐ Rheumatoid Arthritis
- ☐ Osteoporosis
- ☐ Swelling of the feet or legs

Other \_\_\_\_\_

#### ENDOCRINE

- ☐ None
- ☐ Thyroid Disease
- ☐ Diabetes
- ☐ Other \_\_\_\_\_

#### CONSTITUTIONAL

- ☐ None
- ☐ Recent Weight Change
- ☐ Fatigue
- ☐ Night Sweats
- ☐ Fever
- ☐ Other \_\_\_\_\_

#### CARDIOVASCULAR

- ☐ None
- ☐ Angina
- ☐ Calf Pain When Walking
- ☐ Poor Circulation
- ☐ Blood Clots Legs/ Lung
- ☐ Peripheral Artery Disease
- ☐ History of Heart Attack/ Stroke

Dates: \_\_\_\_\_

- ☐ Chest Pain
- ☐ Palpitations
- ☐ Hypertension / High Blood Pressure
- ☐ High Cholesterol
- ☐ Other \_\_\_\_\_

#### GENITOURINARY

- ☐ None
- ☐ Kidney Disease
- ☐ Bladder Problems
- ☐ Other \_\_\_\_\_

#### SKIN

- ☐ None
- ☐ Change in Hair or Nails
- ☐ Thick Scars
- ☒ Open Sores
- ☐ Rashes
- ☐ Skin Cancer
- ☐ Other \_\_\_\_\_

#### RESPIRATORY

- ☐ None
- ☐ Asthma
- ☐ Cough
- ☐ Difficulty Breathing
- ☐ Emphysema
- ☐ Other

#### GASTROINTESTINAL

- ☐ None
- ☐ Irritable Bowel Syndrome
- ☐ Stomach Ulcer
- ☐ Reflux
- ☐ Liver Disease

#### HEMATOLOGIC

- ☐ None
- ☐ Anemia
- ☐ Bruise Easily
- ☐ Blood Clotting Disorder
- ☐ Slow to Heal
- ☐ HIV
- ☐ Other \_\_\_\_\_

#### NEUROLOGICAL/ PSYCHIATRIC

- ☐ None
- ☐ Frequent Headaches/ Migraines
- ☐ Seizures or Convulsions
- ☐ Depression
- ☐ Paralysis or Tremors
- ☐ Anxiety
- ☐ Memory Loss
- ☐ Neuropathy

### FAMILY INFORMATION

MOTHER: ☐ Living; current age \_\_\_\_\_ or ☐ Deceased; age at time of death \_\_\_\_\_

Cause of death: \_\_\_\_\_

FATHER: ☐ Living; current age \_\_\_\_\_ or ☐ Deceased; age at time of death \_\_\_\_\_

Cause of death: \_\_\_\_\_

Please check if there is a history with either parent (indicate which one) for any of the following:

- ☐ CANCER \_\_\_\_\_
- ☐ HIGH BLOOD PRESSURE \_\_\_\_\_
- ☐ STROKE/HEART ATTACK \_\_\_\_\_
- ☐ DIABETES \_\_\_\_\_

# High Point Foot Center



## Patient Medication List

PATIENT NAME \_\_\_\_\_ DOB \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_ Phone: (     ) \_\_\_\_\_ - \_\_\_\_\_

Pharmacy Name \_\_\_\_\_ Phone # \_\_\_\_\_

Medication

Medication

ALLERGIES:     \_\_\_\_\_ NONE (No Known Allergies)     \_\_\_\_\_ SEASONAL ALLERGIES  
\_\_\_\_\_ PENICILLIN     \_\_\_\_\_ SULFA     \_\_\_\_\_ IODINE     \_\_\_\_\_ ASPIRIN     \_\_\_\_\_ ANESTHETICS  
\_\_\_\_\_ LATEX     \_\_\_\_\_ CODEINE     \_\_\_\_\_ DEMEROL     \_\_\_\_\_ DARVOCET     \_\_\_\_\_ CORTISONE  
\_\_\_\_\_ ADHESIVE TAPE     \_\_\_\_\_ FOOD     \_\_\_\_\_ ENVIRONMENTAL     \_\_\_\_\_ OTHER \_\_\_\_\_

TYPES OF REACTIONS \_\_\_\_\_



## Authorization for Release of Information

Name of Patient \_\_\_\_\_

Date of Birth \_\_\_\_\_

HIGH POINT FOOT CENTER is authorized to release protected health information about the above named patient to the entities named below. The purpose is to inform the patient or others in keeping with the patient's instructions.

Entity to Receive Information. Check each person/entity that you approve to Receive information.	Description of information to be released. Check each that can be given to person/entity on The left in the same section.
<input type="checkbox"/> Voice Mail	<input type="checkbox"/> Results of lab tests/ x-rays <input type="checkbox"/> Other _____
<input type="checkbox"/> Spouse	<input type="checkbox"/> Financial <input type="checkbox"/> Medical as follows: _____
<input type="checkbox"/> Parent (provide name) _____	<input type="checkbox"/> Financial <input type="checkbox"/> Medical as follows: _____
<input type="checkbox"/> Other (provide name) _____	<input type="checkbox"/> Financial <input type="checkbox"/> Medical as follows: _____

### Patient Information

I understand that I have the right to revoke this authorization at any time and that I have the right to inspect of copy the protected health information to be disclosed as described in this document, I understand that a revocation is not effective in cases where the information has already been disclosed but will be effective going forward.

I understand that information used or disclosed as a result of this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.

I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing.

This authorization shall be in effect until revoked by the patient.

Signature of Patient or Personal Representative \_\_\_\_\_

Date \_\_\_\_\_

Description of Personal Representative's Authority (attach necessary documentation)

\_\_\_\_\_

Acknowledgment of Receipt  
Of  
Notice of Privacy Practices

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read if I so chose) and understood the Notice.

I also acknowledge that when providing High Point Foot Center with a wireless telephone number or land line number you are giving us your prior express consent to call that number from us or our representative by means of an automatic dialer, pre-recorded artificial voice messages, and/or live operator call.

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Patient Name (please print)

Date

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Parent or Authorized Representative (if applicable)

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Signature