Oklahoma Foot & Ankle
Treatment Center

PATIENT INFORMATION FORM

(PLEASE PRINT)

DATE: ___/____/____

PATIENT NAME: _____ _____ ___ DATE OF BIRTH: ___/___/___ AGE: ___ SEX: M F
LAST FIRST MI

HOME ADDRESS: _____CITY/STATE: _____ ZIP: _____

PHONE # (CIRCLE PREFERRED) MAY WE LEAVE A MESSAGE?

HOME PHONE #: (____) ____-_____ YES NO

WORK PHONE #: (____) ____-_____ YES NO

CELL PHONE #: (____) ____-_____ YES NO

E-MAIL: _____

RACE/ETHNICITY:_____SSN:_____HEIGHT:_____WEIGHT:_____SHOE SIZE:_____

DO YOU HAVE A LEGAL GUARDIAN OR HEALTHCARE POWER OF ATTORNEY? YES NO

IF YES, NAME: _____RELATIONSHIP: _____ PHONE:(____) _____-_____

EMERGENCY CONTACT: _____RELATIONSHIP: _____ PHONE:(____) ____-_____

PRIMARY CARE DOCTOR: _____PHONE:(____) ____-_____ DATE LAST SEEN:_____

PHARMACY: _____ LOCATION: _____PHONE:(____) ____-_____

IS THERE A FAMILY MEMBER OR OTHER PERSON YOU WOULD LIKE FOR US TO SHARE YOUR MEDICAL INFORMATION?

_____ YES NAME(S) _____

_____ NO PHONE # (S) _____

WHO IS RESPONSIBLE FOR PAYMENT? _____RELATIONSHIP TO PATIENT? _____

ADDRESS: _____CITY/STATE: _____ ZIP: _____ PHONE #: (____) ____-_____

HOW DID YOU FIND OUT ABOUT OUR PRACTICE? ___PHYSICIAN ___INTERNET ___FRIEND ___AD ___OTHER

WHOM CAN WE SPECIFICALLY THANK FOR YOUR REFERRAL? _____

INSURANCE INFORMATION

PRIMARY INSURANCE NAME: _____PLAN TYPE: ___HMO___PPO

ADDRESS: _____CITY/STATE: _____ ZIP: _____ PHONE #: (____) ____-_____

INSURED NAME: _____ __DATE OF BIRTH _____EMPLOYER _____

POLICY # _____ GROUP # _____ SSN:_____

SECONDARY INSURANCE NAME: _____PLAN TYPE: ___HMO___PPO

ADDRESS: _____CITY/STATE: _____ ZIP: _____ PHONE #: (____) ____-_____

INSURED NAME: _____ __DATE OF BIRTH _____EMPLOYER _____

POLICY # _____ GROUP # _____ SSN:_____

YOUR MEDICAL HISTORY

LIST ALL MEDICAL CONDITIONS YOU TAKE MEDICATION FOR:_____

_____

PLEASE LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING (INCLUDE PRESCRIPTIONS, OVER-THE-COUNTER MEDS AND HERBAL SUPPLEMENTS):

NAME DOSE HOW OFTEN DO YOU TAKE?

_____
_____
_____
_____
_____
_____
_____

ALLERGIES: ☐ MEDICATIONS _____
☐ ANESTHESIA _____ ☐ FOODS _____
☐ TAPE ☐ LATEX ☐ SHELLFISH ☐ IODINE ☐ OTHER _____ ☐ NONE KNOWN

PLEASE LIST ALL PRIOR SURGERIES:

TYPE OF SURGERY	DATE	TYPE OF SURGERY	DATE
_____		_____	
_____		_____	
_____		_____	

PLEASE LIST ALL PRIOR HOSPITALIZATIONS (OTHER THAN FOR SURGERY):

REASON FOR HOSPITALIZATION	DATE	REASON FOR HOSPITALIZATION	DATE
_____		_____	
_____		_____	
_____		_____	

SOCIAL HISTORY

MARITAL STATUS: ☐ SINGLE ☐ MARRIED ☐ PARTNERED ☐ SEPARATED ☐ DIVORCED ☐ WIDOWED

USE OF ALCOHOL: ☐ NEVER ☐ NO LONGER USE ☐ HISTORY OF ALCOHOL ABUSE
☐ CURRENT USE - TYPE _____ ☐ RARE ☐ OCCASIONAL ☐ MODERATE ☐ DAILY

USE OF TOBACCO: ☐ NEVER ☐ QUIT – HOW LONG AGO? _____ ☐ SMOKE ____ PACKS/DAY FOR ____ YEARS

USE OF RECREATIONAL DRUGS: ☐ NEVER ☐ QUIT – HOW LONG AGO? _____ TYPE _____

☐ Current USE - Type _____ ☐ Rare ☐ Occasional ☐ Moderate ☐ Daily

Employer: _____ Occupation: _____

How much are you on your feet at work? ☐ 10% ☐ 25% ☐ 50% ☐ 75% ☐ 100%

Do others depend upon you for their care? ☐ Children–age(s) _____ ☐ Pet(s)–what kind? _____
☐ Elderly or disabled family member ☐ Other _____

Family History

Do you have a family history of: ☐ Diabetes: Type 1 or Type 2 ☐ Heart Disease
☐ High Blood Pressure ☐ Stroke ☐ Coronary Artery Disease ☐ Thyroid Disease
☐ Rheumatoid Arthritis ☐ Cancer - Type_____

☐ Other _____

Review of systems (Circle all that apply)

- Gastro-Intestinal:
  Nausea / Vomiting / Diahrea / Poor appetite / GERD / Ulcers / Liver Disease / Hepatitis
- Genito-urinary:
  Kidney disease / Dialysis / Frequent urination / Painful urination
- Nervous:
  Numbness / Burning / Tingling / Poor balance / Weakness / Confusion / Fibromyalgia
- Cardiovascular:
  Chest Pain / Heart attack / CHF / feet swell / calf pain / Arrhythmia / Stroke
- Respiratory:
  Shorness of breath / asthma / COPD / wheezing / emphysema / cough / Pneumonia
- Dermatologic:
  Rash / Open wounds / Itching / Psoriasis / Eczema / Deformed nails / Hives / Skin cancer
- Musculoskeletal:
  Osteo arthritis / RA / Back problem / Stiffness / Sciatica / Muscle pain / Instability / Sprain
- Hematologic
  Bleeding disorder / Anemia / HIV / AIDS / Sickle Cell Disease
- Head and eyes
  Migraines / Blurry vision / Double vision / Fainting / Vertigo
- Ears, Nose, Throat
  Ringing in ears / Nose Bleeds / Sinus infection / Trouble swallowing / Dental problems

Current Problem

Please briefly describe the reason for your visit? _____

_____

How long ago did this problem first start? _____ Days / Weeks / Months / Years

Did your pain or problem: ☐ Begin all of a sudden ☐ Gradually develop over time

How would you describe your pain? ☐ No pain ☐ Sharp ☐ Dull ☐ Aching ☐ Burning
☐ Radiating ☐ Itching ☐ Stabbing ☐ Other _____

HOW WOULD YOU RATE YOUR PAIN ON A SCALE FROM 0 TO 10? (PLEASE CIRCLE

(NO PAIN) 0 1 2 3 4 5 6 7 8 9 10 *(WORST PAIN POSSIBLE)*

SINCE THE TIME YOUR PAIN OR PROBLEM BEGAN, HAS IT: ☐ STAYED THE SAME ☐ BECOME WORSE ☐ IMPROVED

HAS THIS PROBLEM AFFECTED YOUR LIFESTYLE OR ABILITY TO WORK? _____

WAS THIS PROBLEM CAUSED BY AN INJURY? ☐ YES (DESCRIBE) _____ ☐ NO

IF YES, WAS IT A WORK-RELATED INJURY? ☐ YES ☐ NO

TO THE BEST OF MY KNOWLEDGE, I HAVE ANSWERED THE QUESTIONS ON THIS FORM ACCURATELY. I UNDERSTAND THAT PROVIDING INCORRECT INFORMATION CAN BE DANGEROUS TO MY HEALTH. I UNDERSTAND THAT IT IS MY RESPONSIBILITY TO INFORM THE DOCTOR AND OFFICE STAFF OF ANY CHANGES IN MY MEDICAL STATUS.

_____ _____

PRINT NAME OF PATIENT, PARENT OR GUARDIAN DATE

_____ _____

IF OTHER THAN PATIENT, RELATIONSHIP TO PATIENT DATE

_____ _____

SIGNATURE DATE

Oklahoma Foot & Ankle Treatment Center Policies and Procedures Agreement

HIPAA PRIVACY POLICY

I have received or been offered a copy of Christopher Seat, DPM's Notice of Privacy Practices. I understand that my information will be used for the purpose of treatment, payment, and healthcare operations as described within.

MEDICAL TREATMENT POLICIES

I hereby authorize the doctor to perform any and all forms of treatment, medication, and therapy that may be indicated in connection with the care of the patient with my consent. I understand that previous to treatment, the doctor or staff will give full explanation of the procedure(s) involved. I authorize the doctor to retrieve a list of my current medications in order to check for any possible interactions with my treatment.

FINANCIAL POLICIES

I have read the attached document titled: Practice Financial Policy. I understand and agree with all information provided, and my signature on that page signifies this.

Patient's Name (print):_____Date:_____

Patient's/Guardian's Signature:_____ Date: _____