Welcome to our office! Please complete the health information below. This information helps us to safely and better care for your needs.

Your Name: **Age:**
Date of Birth: / /

Restoration FOOT & ANKLE

Reason for your visit:

Primary Care Doctor:

Referred to our office by:

PAST MEDICAL HISTORY	**Yes**	**No**
Anaphylaxis (severe allergy)		
Arthritis		
Blood clot history (DVT, PE, etc)		
Cancer		
Chemical addiction		
Circulation problems		
Depression		
Diabetes		
If diabetic, average blood sugar:	**A1C:**	
Gout		
Heart Disease		
Heart Valve condition		
HIV/AIDS or Hepatitis (circle)		
Hypertension (high blood pressure)		
Hyperthyroidism / Hypothyroidism		
Kidney disease		
Liver disease		
Low back condition / Sciatica		
Osteopenia / Osteoporosis		
Pulmonary embolism		

Current Weight:

Height: ***Shoe Size:***

Other doctors you are actively seeing:

Other past medical history not otherwise listed:

MEDICATIONS **(Please include aspirin, birth control pills, over the counter meds and supplements as well. Attached list and report "see list" if applies)**

ALLERGIES ***(please check)***	**Yes**	**No**	***If yes, reaction***
Tape/Adhesives			
Lidocaine (anesthetics)			
Iodine			
Latex			
NSAIDS/anti-inflammatories			
Shellfish			
Metal / Nickel			
X-ray dye			

Other medication allergies (and reactions):

PREVIOUS SURGERIES (note year and any complications):

FAMILY HISTORY ***(If YES Please Specify which family member)***

Amputation	Y / N	Kidney disease	Y / N
Anesthesia problems	Y / N	Lupus/autoimmune disease	Y / N
Arthritis	Y / N	Neurologic disease	Y / N
Clotting Abnormalities	Y / N	Peripheral vascular disease	Y / N
Diabetes	Y / N	Pulmonary embolism	Y / N
Heart disease	Y / N	Unknown	

SOCIAL HISTORY

Lives: *Alone / With Others*

Occupation:

Alcohol use (drinks per week):

History of heavy alcohol use? **Y / N**

Tobacco use: **Y / N** Packs /day:

Previous Smoker: Y / N

History of recreational drug use: Y / N

REVIEW OF SYSTEMS - *Are you currently experiencing…*

	Y	**N**		**Y**	**N**		**Y**	**N**		**Y**	**N**
Acid reflux			**Chills**			Frequent Urination			**Shortness of breath**		
Back pain			Cold fingers/toes			Itching			Skin rash		
Blackouts			Currently Pregnant			**Nausea**			Stiffness/pain in AM		
Calf/leg cramps at night			Diarrhea			Nervousness/anxie			Swelling in legs		
Calf/cramps walking			Dry Throat/Mouth			Numbness in feet			Unstable on feet		
Chest pain			**Fever**			Radiating leg pain			**Vomiting**		

**** Please note: we may need to take x-rays during your visit, so please inform us if there is a chance you may be pregnant. Also, medications we may prescribe (i.e. antibiotics) may reduce the effectiveness of birth control.***

I understand the completeness and accuracy of this information is critical to receiving safe and effective medical care and I have completed this form to the best of my ability.

Patient (or legal guardian) signature: **Date:**

Restoration FOOT & ANKLE

NAME_____ **Age:** _____ **SS#** _____

Address:_____ City/State _____ Zip: _____

Home #_____Mobile #_____ ☐Email: _____

PREFERRED PHARMACY (and general location): _____

Would you like to have access to our patient portal? Yes☐ No☐ (If so, we will send an email invitation for you to enroll.)

OK to receive appointment reminders and messages through our patient portal via email, text and voice as needed? ***Y / N***

OK for Restoration Foot & Ankle to retrieve and view prescription information from your pharmacy? ***Y / N***

Patient's Employer_____Phone_____

Business address _____ City/State_____ Zip_____

Spouse's name _____Birth Date:_____ SS#_____

Emergency Contact (and relation) _____ Phone _____

Person responsible for account: (☐ check here if same as above)

Name _____Relationship_____

Birth date_____SS#_____Employer_____

Work Phone_____ Home phone _____ Mobile _____

Home address _____

Insurance Information	***Primary Insurance***	***Secondary Insurance***
Name of Company:	_____	_____
Policy Holder's Name:	_____	_____

Please read and sign the following authorization and assignment information:

I hereby authorize Dr. Beasley, Dr. Hogue, Dr. Baker and the employees of Restoration Foot & Ankle, PLLC to furnish information to insurance carriers concerning my illnesses and I hereby assign to the doctor(s) all payments for medical services rendered to myself or my dependents. I understand that I am responsible for any amount not covered by insurance or Medicare. I hereby give permission to the above-mentioned doctors to administer treatment and perform such procedures as may be deemed necessary in the diagnosis and/or treatment of my foot or ankle condition. I also authorize the use of clinical photography to document my condition and understand that anonymous images may be used in lectures, scientific papers, and clinical training. I understand that an unannounced no show or same day cancellation may result in a $35 fee should I choose to be reappointed. I understand that two unannounced missed appointments or same day cancellations will result in dismissal from this practice. I authorize the use of my signature on this form for all my insurance submissions. To my knowledge the entered health and personal information is correct. My signature below also confirms that a copy of our privacy and financial policy has been made available to me and any questions I have regarding that policy have been answered.

Patient Signature: _____**Date:**_____
(If patient is under 18, this must be signed by a parent or guardian)

I give permission to Restoration Foot & Ankle, PLLC to discuss my medical and/or billing information with the following persons either by oral or written communication (i.e. family members, friends, etc):

_____

_____

_____

_____