Barry University
Foot and Ankle Institute

11300 NE 2nd Avenue, Miami, FL 33161
P: 305.899.3249 or 1.800.756.6000 ext. 3249
F: 305.899.3253
barry.edu

Patient Information

Date_____

Patient Name_____
Last name First Name Middle Initial
Social Security Number_____ Date of Birth_____

Address _____
City State Zip
Home Phone (_____)_____ Work Phone (_____) _____
Cell Phone (_____)_____ Email _____
Occupation_____ Employer _____
Married ____ Widowed ____ Single____ Minor____ If a Minor, please list name of Person Responsible_____

In case of an emergency, contact: Name_____ Phone (____) _____

Insurance Information

Who is responsible for this account? _____

Name of Insurance_____

Insurance Policy Number or Identification Number_____

Group Number /Name_____

Subscriber/Cardholder Name and Date of Birth_____

Name of Secondary Insurance_____

Insurance Policy number or Identification Number_____

Group number /Name_____

Subscriber/Cardholder Name and Date of Birth_____

Insurance Assignment and Release

I certify that I have insurance coverage with the above listed insurance(s) and assign directly Barry University Foot and Ankle Institute, all insurance benefits, if any, otherwise payable to me for services rendered. I authorize release to the indicated insurance company (ies) any medical information needed to determine these payments for relevant services._____Initial

I hereby agree to pay Barry University Foot and Ankle Institute, in a timely fashion, for any and all services rendered which may or may not be covered by my insurance. This includes any co-payment, deductible and/or insurance payments that I may receive as a result of services rendered. Should my account not be paid in a timely manner I understand that I will be held responsible for any further collection and/or attorney fees. An additional fee of $25.00 will be imposed in the event of a returned check for insufficient funds._____Initial

Treatment Authorization: I hereby authorize treatment by the Barry University Foot & Ankle Institutes. I understand that this is a teaching clinic and that students may participate in my care. I consent that photographs or videotapes (lower extremities only) may be taken for educational purposes._____Initial

ALL CHARGES ARE DUE AT THE TIME OF SERVICE

I hereby authorize my physician_____to obtain records from other sources as may be needed in the treatment of this patient. I hereby authorize the release if information concerning this patient's treatment to other physicians involved in the care and treatment of patient. I authorize the release of information to the insurance company as needed to pay for charges incurred by this patient.
I hereby authorize payment of insurance benefits otherwise due to me to be made directly to the above physician or hospital.
I understand that I am responsible for any amount not covered by the insurance company.

_____ _____ _____
Signature Print name (Patient, Beneficiary or Guardian) Date

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PATIENT HISTORY

* Please fill out all forms to the best of your ability. The staff will go over the form and answer any questions you may have.

Name:_____Date:____/_____/____

Age: _____ Height: _____ Weight: _____ Shoe Size: _____

1) What is the main problem with your feet or ankles? _____

_____

2) When did you first notice the condition? _____

3) Is this an injury? _ _Yes___No If Yes, when did it occur?_____/_____/_____
If Yes, did it happen at work? ___Yes ___No Are you claiming Workman's Comp.?_Yes__No

4) Check all of the following that apply:

Type of Pain ___Burning _Tingling _Sharp _Dull Ache
___Shooting _Stabbing _Numbness _Throbbing

When Painful _Upon standing ___During Walking ___After Walking
___During Sports ___Worse with Activity ___Better as Activity Continues
___Worse when standing ___With Shoes ___Without Shoes
___A.M. _P.M. ___Lying in Bed ___Always

5) How painful is your condition? If 0- "no pain" and 10 – "the worst pain you have ever experienced", please circle your pain level:

0 1 2 3 4 5 6 7 8 9 10

6) How has this affected your daily routine and what activities does this keep you from performing? _____
_____

7) Have you had foot care before?___Yes___No By whom and when: _____
_____

_____

MEDICATIONS

Pharmacy: _____ Number: (____) ----------_____

Medication	Dosage	How Often Taken?	What is it taken for?

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ALLERGIES

☐ NONE ☐ OTHER

☐ Penicillin	☐ Sulfa	☐ Iodine	☐ Aspirin	☐ Anesthetics	☐ Latex
☐ Codeine	☐ Demerol	☐ Darvocet	☐ Cortisone	☐ Environmental	☐ Food

Type of Reactions: _____

MEDICAL HISTORY

* Please check any of the following conditions that you have or have had in the past.

☐ Diabetes	☐ Fibromyalgia	☐ Tumors	☐ Epilepsy	☐ Nerve Conditions	☐ Heart Problems
☐ Arthritis	☐ Gout	☐ Asthma/COPD	☐ Glaucoma	☐ Stomach Ulcers	☐ Skin Disorders
☐ Tuberculosis	☐ Anemia	☐ Bursitis	☐ Aids (HIV)	☐ Lung Disease	☐ Kidney Problems
☐ Sickle Cell	☐ Stroke	☐ Hepatitis	☐ Osteoporosis	☐ Bleeding Problems	☐ Colitis/Crohn's
☐ Mental Disorders	☐ Poor Circulation		☐ High Blood Pressure	☐ Joint Implants	☐ Thyroid Disease
☐ Rheumatic Fever	☐ Heart Burn / Reflux		☐ Sexually Transmitted Diseases		☐ High Cholesterol

☐ Cancer; type_____ Other: _____

☐ Diabetes; what is the name, phone number, and address of the doctor treating you for diabetes? _____

_____

Primary Care Physician name:_____ Phone number: _____

When was your last visit with your PCP?____/___/___ What is your average blood sugar reading?_____

Are you pregnant? ___Yes ___No How many months? _____

Are you up to date on your immunizations?____Yes____No

SURGICAL HISTORY

Procedure	Date	Complications

7) Have you ever been hospitalized other than for surgery? _ _Yes _ _No Explain_____

8) Have you ever had an injury to the lower extremity? _ _Yes____No Explain_____

FAMILY HISTORY

* Please check all that apply

	FATHER	MOTHER	BROTHER	SISTER
Diabetes				
Heart Disease				
High Blood Pressure				
Arthritis				
Gout				
Thyroid				
Cancer (what type)				
Other				

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SOCIAL HISTORY

Date of last physical Exam:____/___/___ Occupation: _____

Do you exercise? ___Never____Daily_____Weekly Have you traveled out of the country in the past 6 months?_____Yes_____No.

How many hours do you sleep a night:_____? Do you any pets at home?_____Yes_____No. What Type?_____

Do you smoke tobacco? ___Yes____No
If Yes: # packs per day? ___ # cigarettes per day? ___ # of years smoking? ___

If No: Did you ever smoke?____Yes__No

Do you drink alcohol?____Yes__No
If Yes: How much? _<1 per week ___1-2 per week _1-2 per day ___more than 3 per day

Recreational drug use
Any type of drug use is a personal choice and will in no way adversely affect your relationship with the doctor. However, many drugs can interact with other medications and treatments with potential life threatening effects. Therefore, it is extremely important that you answer honestly. Your response will be held in the most strict patient-doctor confidentiality.
Answer:____Yes____No If Yes: What substance and how often used? _____

REVIEW OF SYSTEMS
* If you are experiencing any of the following please circle
Head: chronic headaches, concussions, dizziness, loss of consciousness. **Eyes:** glasses, contacts, double vision, blurred vision, blindness, cataracts. **Ears:** decreased or loss of hearing, ringing in the ears, chronic earaches. **Nose:** drainage or infection, blockage, bleeding, sinusitis. **Throat:** chronic tonsillitis, laryngitis, difficulty swallowing, loss of speech. **Cardiovascular:** chest pain, shortness of breath, palpitations, murmurs, heart valve disease, anemia, leg cramps. **Respiratory:** bronchitis, pneumonia, difficulty breathing, wheezing, chronic cough. **Gastrointestinal:** nausea, vomiting, diarrhea, constipation, weight gain or loss, blood in stool, black stool, excessive gas, loss of appetite. **Genitourinary:** chronic kidney or bladder infections, problems voiding, pain with urination, dark or bloody urine, discharge from penis or vagina. **Gynecologic:** Irregular or painful periods, absence of period if not in menopause, vaginal discharge.
Do your legs swell? ___Yes ___No Do you have back problems or have had a back injury?____Yes____No

Other symptoms:_____
____ I am not experiencing any of the above symptoms.

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NOTICE OF PRIVACY PRACTICES (HIPAA REGULATIONS)

_____You were provided with a document entitled "Notice of Privacy Practices." It is required by governmental regulations that all medical facilities provide you with this notice. Please check the box to acknowledge that you have read (or had the opportunity to read if you chose) and understand the notice. This is a copy of the notice that is yours to keep. If you do not want the copy, simply return it to the receptionist with your other materials.

CONSENT

I certify that the information above is true and correct to the best of my knowledge. I give permission to the doctor to administer and perform such procedures, including therapeutic and diagnostic injections, as may be deemed necessary I the diagnosis and/or treatment of my feet.

_____ _____
Signature of Patient (or Authorized Representative) Date

_____
Patient's Name (PRINT)

_____ _____
Name of Authorized Representative, if applicable (PRINT) Indicate Relationship to Patient

_____ _____
Interpreter's Signature Name of Interpreter (Print)