Today's Date:

Reason For Visit **Referred By**

Patient's Name (last, first) ,

Address, City, State, Zip ,

Email Address

Patient Info

Age	DOB	Sex	Marital Status

Home Phone	Mobile Phone	Work Phone (Ext)

Employer's Name	Address & Title

Emergency Contact	Phone Number	Relationship

Insurance Info

Is your injury a result of an accident?	If yes please select the type of accident.
Primary Insurance Carrier	**Phone**
ID / Claim #	**Adjuster / Case Manager**
Secondary Insurance	**Phone**
ID / Claim #	**Group #**
Tertiary Insurance	**Phone**
ID / Claim #	**Group #**

If you are being represented by an attorney please provide their complete information	
Name	**Phone**
Address, City, State, Zip ,	

Medical History

Height:	**Weight:**
Do You Smoke?	**How Much?**
Do you Consume Alcohol?	**How Much?**

Mark “Y” or “N” to indicate if you have had any of the following

Y N	Y N	Y N
HIV / AIDS	Epilepsy	Rash
Allergies to Anesthetics	Eye Problems	Respiratory Disease
Allergies to Medicine / Drugs	Fainting	Rheumatic Fervor
Anemia	Foot / Leg Cramps	Shortness of Breath
Angina	Gout	Sinus Problems
Arthritis	Headaches	Special Diet
Artificial Heart Valves / Joints	Heart Disease	Stroke
Asthma	Hemophilia	Swelling in Ankles / Feet
Back Problems	Hepatitis / Jaundice	Swollen Neck Glands
Bleeding Disorders	High Blood Pressure	Tired Feet
Cancer	Kidney Problems	Tuberculosis
Chemical Dependency	Liver Disease	Ulcers
Chest Pain	Low Blood Pressure	Varicose Veins
Chronic Diarrhea	Neuropathy	Venereal Disease
Circulatory Problems	Phiebitis	Weight Loss Unexplained
Diabetes	Psychiatric Care	
Ear Problems	Radiation Treatment	

Surgeries you have had:
Hospitalizations other than the surgeries listed above:

Family Physician:	**Last Visit:**	
Are you now, or have you been under any other doctor's care for any reason over the past two years?	**Yes**	**No**
If yes please explain:		
Do you take medications? List all over the counter, vitamins, and prescriptions		
Pharmacy name(s) and phone numbers		

Do you take oral contraceptives?	Y N

Allergies (Check all that apply)

Adhesive / Tape	Local Anesthetics
Anticoagulant Therapy	Novocaine
Aspirin	Penicillin
Codeine	Seafood
Demerol	Sulfide
Iodine	

Other:

Consents

Patient name:

Today's Date:

ASSIGNMENT OF BENEFITS AND INSURANCE AUTHORIZATION

I hereby authorize Lower Keys Foot & Ankle Surgery to furnish information to insurance carriers concerning my illness and treatments. I hereby assign all payments, for medical services rendered to myself or my dependent, to the physicians. I understand that I am responsible for any amount not covered by my insurance. I am assigning all my rights unconditionally to Lower Keys Foot & Ankle Surgery to pursue any medical bills, relating to treatment or care by this office in addition to the above.

NO FAULT AND/OR WORKER'S COMPENSATION PATIENTS

I hereby authorize the release of my medical chart, bills and/or any other information related to my treatment, to my attorney .

I further authorize Lower Keys Foot & Ankle Surgery to pursue payment of my bills. I understand that all medical bills will be submitted to the responsible insurance carrier and will only be submitted to my medical insurance carrier in the event that payment is denied and/or there is a remaining balance, which I am responsible for. I understand that I am directly and fully responsible for all medical bills submitted by you for services rendered to myself or my dependent and that this agreement is made solely for your additional protection and in consideration of your awaiting payment. I further understand that your attorney, if needed will arbitrate my bills for payment.

HIPPA PRIVACY ACKNOWLEDGEMENT

I, , acknowledge that I have been provided with a copy of Lower Keys Foot & Ankle Surgery privacy notice.

This notice is effective as of today's date.

PHOTOGRAPH CONSENT

I, , authorize my picture be taken. I understand that my photograph will be attached to my medical chart and only used for identification purposes. I understand & do not authorize my image be used for any other purpose.

Declined - You may opt not have your photograph taken but must supply us with picture identification for our records.

Lower Keys Foot & Ankle Surgery - Robert W. Hutchison, DPM, FACFAS - 1111 12th St STE 211, Key West, FL 33040