

**ARCHER FOOT & ANKLE CLINIC**

**WELCOME TO OUR OFFICE**

PLEASE PRINT & CHECK THE FOLLOWING PATIENT INFORMATION FOR OUR RECORDS.

PATIENT'S NAME \_\_\_\_\_

BIRTH DATE \_\_\_\_\_ SOC.SEC# \_\_\_\_\_

ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

AREA CODE&PHONE#-HOME \_\_\_\_\_ WORK \_\_\_\_\_

AREA CODE & FAX# HOME \_\_\_\_\_ WORK \_\_\_\_\_

AREA CODE & CELL# HOME \_\_\_\_\_ WORK \_\_\_\_\_

EMAIL HOME \_\_\_\_\_ WORK \_\_\_\_\_

MARTIAL STATUS: SINGLE \_\_\_\_\_; MARRIED \_\_\_\_\_; WIDOWED \_\_\_\_\_; DIVORCED \_\_\_\_\_; SEPARATED \_\_\_\_\_

OCCUPATION \_\_\_\_\_ EMPLOYER \_\_\_\_\_

EMERGENCY CONTACT \_\_\_\_\_ PHONE# \_\_\_\_\_

REFERRED BY \_\_\_\_\_

PRIMARY CARE PHYSICIAN \_\_\_\_\_ LAST VISIT \_\_\_\_\_

**INSURANCE-REIMBURSEMENT INFORMATION & AUTHORIZATION**  
WE NEED TO COPY YOUR INSURANCE CARD(S)

INSURANCE: HMO \_\_\_\_\_; PPO \_\_\_\_\_; PRIVATE \_\_\_\_\_; MEDICARE \_\_\_\_\_; MEDICAID/PUBLIC AID \_\_\_\_\_;  
WORKMEN'S COMP \_\_\_\_\_; NONE \_\_\_\_\_.

(ALL HMO PATIENTS MUST HAVE A CURRENT REFERRAL FROM THEIR PRIMARY CARE PHYSICIAN AND ALL MEDICAID/PUBLIC AID PATIENTS MUST HAVE A CURRENT CARD/LETTER TO BE SEEN. ALL COPAYS ARE DUE AT TIME OF SERVICE)

I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS INSURANCE CLAIMS. I ALSO REQUEST PAYMENT OF GOVERNMENT OR INSURANCE BENEFITS EITHER TO MYSELF OR THE PARTY THAT ACCEPTS ASSIGNMENT. I AUTHORIZE PAYMENTS DIRECTLY TO DR. THOMAS A. BUIVIDAS AND/OR THE ARCHER FOOT & ANKLE SURGICAL FACILITY.

AUTHORIZED SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

PERSON FINANCIALLY RESPONSIBLE (IF OTHER THAN ABOVE):

NAME \_\_\_\_\_ RELATIONSHIP \_\_\_\_\_

EMPLOYER \_\_\_\_\_ SOC.SEC# \_\_\_\_\_

AREA CODE & PHONE# HOME \_\_\_\_\_ WORK \_\_\_\_\_

**GENERALIZED CONSENT TO TREAT**

I HEREBY GIVE PERMISSION TO DR. BUIVIDAS TO ADMINISTER TREATMENT & PERFORM SUCH GENERAL PROCEDURES AS DEEMED NECESSARY FOR THE DISGNOSIS &/OR TREATMENT OF FOOT/ANKLE CONDITION(S) ON THE ABOVE NAMED PATIENT.

AUTHORIZED SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

**MEDICAL HISTORY** NAME \_\_\_\_\_ DATE \_\_\_\_\_

AGE \_\_\_\_\_ RACE \_\_\_\_\_ SEX \_\_\_\_\_ HEIGHT \_\_\_\_\_ WEIGHT \_\_\_\_\_

WHAT IS THE FOOT/ANKLE PROBLEM THAT YOU ARE HERE FOR? \_\_\_\_\_

HOW LONG HAS IT BOTHERED YOU? \_\_\_\_\_

ANY PREVIOUS TREATMENT? \_\_\_\_\_

ANY OTHER PROBLEMS? \_\_\_\_\_

PLEASE CHECK PAST OR PRESENT CONDITIONS THAT APPLY TO YOU

- \_\_\_\_\_ ARTHRITIS/JOINT PROBLEMS
- \_\_\_\_\_ BREATHING/LUNG PROBLEMS
- \_\_\_\_\_ BACK/SPINE PROBLEMS
- \_\_\_\_\_ BLOOD CLOTS
- \_\_\_\_\_ BLOOD DISORDERS/ANEMIA
- \_\_\_\_\_ BLOOD THINNERS
- \_\_\_\_\_ BLEEDING PROBLEMS
- \_\_\_\_\_ BONE PROBLEMS
- \_\_\_\_\_ CANCER
- \_\_\_\_\_ CHRONIC PAIN
- \_\_\_\_\_ CIRCULATION PROBLEMS
- \_\_\_\_\_ CURRENT DOCTOR CARE
- \_\_\_\_\_ CURRENTLY PREGNANT
- \_\_\_\_\_ DIABETES
- \_\_\_\_\_ DIABETIC NEUROPATHY
- \_\_\_\_\_ EYE/EAR/NOSE/THROAT PROBLEMS
- \_\_\_\_\_ FATIGUE
- \_\_\_\_\_ HEART CONDITION
- \_\_\_\_\_ HIGH BLOOD PRESSURE
- \_\_\_\_\_ INTESTINAL PROBLEMS
- \_\_\_\_\_ INHERITED CONDITIONS
- \_\_\_\_\_ INFECTIOUS DISEASES
- \_\_\_\_\_ LEG/FOOT CRAMPS
- \_\_\_\_\_ LIVER PROBLEMS
- \_\_\_\_\_ MUSCLE PROBLEMS
- \_\_\_\_\_ MENTAL HEALTH CONDITION
- \_\_\_\_\_ NERVE/NEUROLOGICAL PROBLEM
- \_\_\_\_\_ PODIATRY CARE
- \_\_\_\_\_ SKIN DISORDERS
- \_\_\_\_\_ THYROID PROBLEMS
- \_\_\_\_\_ URINARY/KIDNEY DISORDERS
- \_\_\_\_\_ VARICOSE VEINS
- \_\_\_\_\_ SEIZURE DISORDERS
- \_\_\_\_\_ SLEEP PROBLEMS
- \_\_\_\_\_ WALKING PROBLEMS
- \_\_\_\_\_ WEIGHT PROBLEMS
- \_\_\_\_\_ OTHER CONDITIONS/PROBLEMS

LIST PREVIOUS SURGERIES/HOSPITALIZATIONS \_\_\_\_\_

LIST CURRENT MEDICATIONS & DOSES \_\_\_\_\_

LIST ALLERGIES/SENSITIVITIES \_\_\_\_\_

HABITS (HOW MUCH & HOW OFTEN) TOBACCO \_\_\_\_\_ ALCOHOL \_\_\_\_\_

SIGNATURE \_\_\_\_\_ DOCTOR'S SIGNATURE \_\_\_\_\_