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Diplomate American Board of Orthopedics

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PATIENT INFORMATION SHEET

Date: _____

Last Name: _____ First Name: _____ Middle Initial: ____ Sex: □ Male □ Female

Social Security # _____-_____-_____ Birth Date: _____

Street: _____ City _____State:_____ Zip_____

Home Phone: (_____) _____ Work Phone: (_____) _____ Cell Phone: (_____) _____

Marital Status: □Single □Married □Divorced □Widowed Age: _____ Weight _____lbs Shoe Size _____

Responsible Party (if patient is a minor): _____ Relationship: _____
Full Name

Emergency Contact: _____ Phone: (_____) _____Relationship: _____

Pharmacy Name: _____ Pharmacy Phone: (_____) _____

INSURANCE INFORMATION:

Do you have medical Insurance? □ Yes □ No
Who is your primary care physician? _____ Physician Phone: (_____) _____

Office Location: _____
City/Town/State

EMPLOYMENT INFORMATION:

Occupation: _____ Patient employed by: _____

Business Address: _____

MEDICAL HISTORY:

Current Foot/Ankle Problem: _____

Do you have or have you ever been treated for:

- ☐ GERD
- ☐ Stomach Ulcer
- ☐ Liver Disease
- ☐ Hepatitis
- ☐ AIDS/HIV
- ☐ Hypothyroid
- ☐ Hyperthyroid
- ☐ Diabetes
- ☐ Poor Circulation
- ☐ Kidney Disease
- ☐ Anemia
- ☐ Heart Attack
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Arrhythmia
- ☐ Valvular Heart Dz
- ☐ Asthma
- ☐ Lung Disease
- ☐ Rheumatoid Athritis
- ☐ Arthritis
- ☐ Osteoprosis
- ☐ Gout
- ☐ Psychiatric Disorder
- ☐ Alzheimers
- ☐ Epilepsy
- ☐ Fibromyalgia/RSD
- ☐ Stroke
- ☐ Hearing/Ear Disorder
- ☐ Glaucoma
- ☐ Nerve Disorder
- ☐ Sciatica
- ☐ Cancer
- ☐ Other

List any past surgical history: _____

List current medications: _____

_____

Allergies to medications? _____

Do you? □ Smoke Tobacco □ Drink Alcohol Regularly □ Recreational Drug Abuse

Family History: □ Diabetes □ Heart Disease □ Poor Circulation □ Foot problems □ Other

Whom may we thank for referring you? _____

SIGNATURE OF PATIENT: _____

Part One:

Acknowledgement Of Receipt of Notice Of Privacy Practices

I acknowledge that I was provided with a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read if I so chose) and understood the Notice.

_____

Print - Patient Name
OR Print - Parent/Authorized Representative Name (if applicable)

_____ _____

Signature of Patient Date
OR Parent/Authorized Representative

Part Two:

Authorization to Pay Benefits To Physician

I hereby authorize and request payment directly to Dr. Sean Kaufman and/or Dr. Michael Rallatos for any surgical and/or medical benefits due under the terms of this insurance policy for services rendered.

_____ _____

Signature of Patient Date
OR Parent/Authorized Representative