ASCEND
FOOT & ANKLE CENTER

Lafayette Office
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Patient Registration

Patient Information

Patient Full Name: ☐Mr. ☐Mrs. ☐Ms. ☐Dr.	**Last**	**First**	**M.I.**			☐M ☐F
By what name do you preferred to be addressed?			Single ☐	Married ☐	Divorced ☐	Separated ☐	Widowed ☐	Partner ☐
Patient's Address						
City	**State**	**Zip**				
Preferred Phone ☐ Home ☐ Cell ☐ Work		**Alternative Phone** ☐ Home ☐ Cell ☐ Work				
E-mail Address (required for access to your online patient portal)						
Social Security #	**Birth Date**	**I would like automated reminders by:** ☐ Email ☐ Phone ☐ Text (Choose up to 3)				
Employer		**Occupation**				
Emergency Contact/Relationship		**Phone**				

Do you give permission to Dr. Hofer Ogilvie to use your photos/videos? ☐ Yes ☐ No

Lower Extremity Medical History, Referral Information, Doctors and Pharmacies

Name: _____ **Date:** _____

What is the chief complaint(s) that brings you to our office for medical treatment? (Include foot, ankle, leg, knee, hip and back complaints: _____

_____

_____

_____

Symptoms of Current Problem (circle or fill in your answer)

Which Side: ☐ Right ☐ Left ☐ Both **Type of Pain**:☐Dull ☐ Achy ☐Throbbing ☐Burning ☐Sharp ☐ Shooting

Area of Pain:☐ Bottom of Heel ☐ Back of heel ☐ Arch ☐ Ball of foot ☐ Big toe ☐ Top of foot ☐ Ankle ☐ No Pain

☐ Other/Details: _____

On set:☐Slow ☐Sudden ☐Traumatic **Has pain gotten**: ☐ Better ☐ Worse ☐ Stayed the Same

How long has this been a problem for you?: ☐ Days ☐ Weeks ☐Months ☐Years

What aggravates condition? ☐ Walking ☐ Running ☐ Standing ☐ Shoes ☐ Activities ☐ First steps after rest

☐ Other: _____ **Severity**: ☐ Mild ☐ Moderate ☐ Severe

What have you tried for the pain? ☐ Changing shoes ☐ Anti-inflammatory meds ☐ Decreasing activities ☐ Ice

☐ Heat ☐ Prefabricated Arch Supports ☐ Custom Orthotics ☐ Stretching ☐ Injections ☐ Physical Therapy ☐ Surgery

☐ Antibiotics ☐ Other OTC Meds ☐ Padding ☐ Massage ☐ Acupuncture ☐ Soaking

☐ Other: _____

After it starts, how long does pain last? _____

Have you ever had a similar pain? (describe, including treatments received) _____

_____

How did you hear about our office?

☐ Relative ☐ Friend ☐ Google ☐ Bing ☐ Other Web Search ☐ Facebook ☐ Yelp

☐ Insurance Company ☐ Mail ☐ Phone Book ☐ TV ☐ Other: _____

☐ From My Doctor (name/specialty/city): _____

Who is your primary care physician and what other doctors treat you regularly?

Primary Care Physician: _____ ☐ MD ☐ DO ☐ PN

Date last seen: _____ ☐ I don't have a primary care physician

Other doctors and their specialties: _____

_____

List your primary pharmacy (name and location) - This is where we will send any prescriptions

Primary pharmacy (include city and street): _____

NAME: _____ DATE: _____

Past Medical History, Social and Family History Form

General

What is your weight: _____

What is your height: _____

What is your shoe size: _____

Allergies and Drug Intolerance

- ☐ Adhesive/Tape
- ☐ Aspirin
- ☐ Codeine
- ☐ Iodine
- ☐ Local Anesthetics
- ☐ Penicillin
- ☐ Seafoods
- ☐ Sulfa
- ☐ Other: _____
- ☐ No Known Allergies

Medications

List all medications(and doses) you are taking:

_____ dosage: _____
_____ dosage: _____
_____ dosage: _____
_____ dosage: _____
_____ dosage: _____
_____ dosage: _____
_____ dosage: _____
_____ dosage: _____
_____ dosage: _____
_____ dosage: _____
_____ dosage: _____

Surgeries, Injuries, Illnesses

List surgeries, serious injuries, and illnesses not previously listed:

_____
_____
_____
_____
_____
_____
_____
_____

General Medical History

Mark "yes" or "no" to indicate if you or a family member have any of the following:

Personal			Family
☐ yes	☐ no	Anemia	☐ yes
☐ yes	☐ no	Arthritis: Type: _____	☐ yes
☐ yes	☐ no	Artificial Heart Valve or Joints	☐ yes
☐ yes	☐ no	Asthma	☐ yes
☐ yes	☐ no	Back Problems	☐ yes
☐ yes	☐ no	Bleed easily	☐ yes
☐ yes	☐ no	Cancer	☐ yes
☐ yes	☐ no	Chemical Dependency	☐ yes
☐ yes	☐ no	Chest Pain	☐ yes
☐ yes	☐ no	Circulatory Problems	☐ yes
☐ yes	☐ no	Diabetes	☐ yes
☐ yes	☐ no	Epilepsy	☐ yes
☐ yes	☐ no	Fibromyalgia	☐ yes
☐ yes	☐ no	Gout	☐ yes
☐ yes	☐ no	Heart Disease	☐ yes
☐ yes	☐ no	Hemophilia	☐ yes
☐ yes	☐ no	Hepatitis	☐ yes
☐ yes	☐ no	High Blood Pressure	☐ yes
☐ yes	☐ no	HIV Positive	☐ yes
☐ yes	☐ no	Kidney Problems	☐ yes
☐ yes	☐ no	Leg Cramps	☐ yes
☐ yes	☐ no	Liver Disease	☐ yes
☐ yes	☐ no	Lung/Respiratory	☐ yes
☐ yes	☐ no	Menopause	☐ yes
☐ yes	☐ no	Mental Illness	☐ yes
☐ yes	☐ no	Phlebitis / Clots	☐ yes
☐ yes	☐ no	Psoraisis	☐ yes
☐ yes	☐ no	Rheumatic Fever	☐ yes
☐ yes	☐ no	STD	☐ yes
☐ yes	☐ no	Stroke	☐ yes
☐ yes	☐ no	Thyroid Problems	☐ yes
☐ yes	☐ no	Tuberculosis	☐ yes
☐ yes	☐ no	Ulcers—Stomach	☐ yes
☐ yes	☐ no	Weight Change	☐ yes

Mental / Emotional

- ☐ yes ☐ no Eating Disorder
- ☐ yes ☐ no Anxiety
- ☐ yes ☐ no Depression
- ☐ yes ☐ no Psychiatric
- ☐ yes ☐ no Alcoholism

Exercise and Orthotics

In what athletic activities do you participate?

_____

days per week exercising? _____
How many minutes of exercise per week_____
Do you wear store-bought arch supports? ☐yes ☐no

Do you wear custom orthotics? ☐ yes ☐ no

If yes, who made them: _____

How old are the orthotics: _____

Social History

Your occupation?

_____

Do you smoke? ☐ yes ☐ no

Are you a past smoker? ☐ yes ☐ no

How Much? packs/day_____

Years Smoked:_____

Drink Alcohol?: ☐ yes ☐ no
How Much:_____

Recreational Drugs? ☐ yes ☐ no
What: _____

Pregnant or possibly pregnant? ☐ yes ☐ no

The US HITECH Act requires us to ask the following questions:

Preferred Language: ☐ English
☐ Other: _____

Race: ☐ American Indian or Alaska native
☐ Asian ☐ Asian Indian
☐ Black/African American
☐ European
☐ Native Hawaiian/Pacific Islander
☐ White
☐ Other: _____
☐ **Decline**

Ethnicity: ☐ Hispanic/Latino
☐ Not Hispanic/Latino
☐ Other: _____
☐ **Decline**

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NOTICE OF PRIVACY PRACTICE ACKNOWLEDGMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1998 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I acknowledge that I have received your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name _____

Relationship to Patient _____

Signature _____

Date _____

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgment on the Notice of Privacy Practices Acknowledgment, but was unable to do so as documented below:

Date: _____ Initials: _____ Reason: _____

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Financial Policy

Your insurance policy is a contract that exists between you and your insurance company. Our relationship is with you, the patient, and not the insurance company. The patient or responsibly party is responsible for their bill being paid in full.

Please initial each line indicating your understanding of our policies:

_____ **PAYMENT:** Full payment is due at time of service. Payment for evaluation and management services at minimum will be required before seeing the doctor. Additional procedures/services may be recommended by the doctor. You will be informed of these charges before proceeding with treatment.

____**NO SHOW(failure to present for your appointment): 24 hours-notice** is required for cancellation of your appointment and failure to do so will incur a **$50** fee. Failure to provide **24 hours-notice** for a scheduled office procedure will incur a **$100** fee.

_____**BALANCES/COLLECTION FEES:** If payment of an outstanding balance is not received within 30 days from the postmark date of a mailed statement or e-statement time stamp, a **$10** re-billing fee may be added to each additional statement. Patients with balances more than 90 days overdue will be turned over to collections and a **$35** administrative fee will be applied.

____**FMLA/DISABILITY/MEDICAL RECORDS:** There is a **$40** charge for having the doctor complete these forms. Requested forms will be completed within 72 hours of diagnosis and care plan. There is a **$30** fee to obtain a copy of your medical records.

I have read and understand these financial policies. Patient

Name (print): _____

Patient/Responsible Party Signature:_____

Date:___/____/_____