FOUNDATION
FOOT & ANKLE
SPECIALISTS

www.FoundationFoot.com

Auburn
206 Auburn Ave. | Auburn, WA 98002
ph 253.245.9299 | fax 253.604.1259

Tacoma
4050 S 19th St. #202 | Tacoma, WA 98405
ph 253.565.3355 | fax 253.564.6744

Patient Information

Patient's Name: _____ Date of Birth: _____

Address: _____ City: _____ Zip: _____

Cell Phone: _____ Home Phone: _____

Social Security#: _____ Email: _____

Sex: ☐ Male ☐ Female Marital Status: ☐ single ☐ married ☐ widowed ☐ divorced ☐ separated

Race: _____ Ethnicity: _____ Sexual Orientation (optional) _____

Preferred Language (if not English): _____

Emergency Contact: _____ **Relationship:** _____

Home/Cell Phone: _____ **Work Phone:** _____

Legal Guardian or Spouse

Name: _____ Date of Birth: _____

Social Security#: _____ Sex: ☐ Male ☐ Female

Cell Phone: _____ Email: _____

☐ Check box if address and home phone is same as above

Address: _____ City: _____ Zip: _____

Home Phone: _____

Employer Information

Employer: _____ Occupation: _____

Employer Address: _____ City: _____ Zip: _____

Employer Phone: _____

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Insurance Information

Primary Insurance

Insurance Company: _____

Insurance Type: ☐ PPO ☐ HMO

Member ID#: _____

Group#: _____

Insurance Phone#: _____

☐ Check box if primary subscriber is yourself

Primary Subscriber _____

Subscriber Date of Birth: _____

Subscribe Soc Sec#: _____

Relationship to Patient: _____

Secondary Insurance

Insurance Company: _____

Member ID#: _____

Group#: _____

Insurance Phone#: _____

☐ Check box if primary subscriber is yourself

Primary Subscriber _____

Subscriber Date of Birth: _____

Subscribe Soc Sec#: _____

Relationship to Patient: _____

THE INFORMATION PROVIDED IS TRUE TO THE BEST OF MY KNOWLEDGE. I HEREBY AUTHORIZE DR. SUNG, DR. LEE, OR DR. McBRIDE AND HIS ASSISTANTS TO INITIATE THE DIAGNOSIS AND TREATMENT OF MY CONDITION, TO USE X-RAY EXAMINATION AND PHOTOGRAPHS AS NECESSARY.

I HEREBY AUTHORIZE MY INSURANCE BENEFITS TO BE PAID DIRECTLY TO THE HEALTHCARE PROVIDER. I UNDERSTAND THAT I AM PERSONALLY RESPONSIBLE FOR CHARGES NOT COVERED BY MY INSURANCE AGREEMENT. I ALSO AUTHORIZE ANY RELEASE OF INFORMATION BY MY PROVIDER AS REQUIRED BY THE INSURANCE COMPANY FOR THIS ACCOUNT TO BE PAID. RELEASE OF INFORMATION MAY INCLUDE: (1) ALCOHOL AND/OR DRUG ABUSE TREATMENT, (2) PSYCHIATRIC DIAGNOSIS, TREATMENT, AND SUMMARIES, (3) TEST RESULTS FOR HUMAN IMMUNODEFICIENCY (HIV), SEXUALLY TRANSMITTED DISEASES (STD), AND THE TREATMENT THEREOF. I HEAR BY RELEASE FOUNDATION FOOT AND ANKLE SPECIALISTS, PLLC, DR. SUNG, DR. LEE, AND DR McBRIDE FROM ALL LEGAL RESPONSIBILITY THAT MAY ARISE FROM DISCLOSURE OF MY RECORDS AS PROVIDED BY THIS PARAGRAPH.

I AM FINANCIALLY RESPONSIBLE FOR ANY BALANCE DUE. I AGREE TO MAKE PAYMENT ARRANGEMENTS; PAY FIVE DOLLARS OR 1% INTEREST PER MONTH (WHICH EVER IS GREATER) ON UNPAID BALANCES OVER 60 DAYS AND ALL THE REASONABLE EXPENSES SUCH AS ATTORNEY FEES AND COURT COSTS SHOULD THE ACCOUNT BE REFERRED FOR COLLECTIONS.

Signature: _____ Date: _____

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Patient Health Questionnaire

Patient Name: _____ Today's Date: _____

Height: _____ ft _____ inches Weight: _____ lbs Shoe Size: _____

Reason for Today's Visit: _____

Referred By: _____

Primary Care Physician: _____ Last Seen by PCP: _____

PCP Phone#: _____

Pharmacy (Name and Address): _____

Pharmacy Phone#: _____

Allergies (check all that apply): ☐ Penicillin ☐ Sulfa ☐ Codeine ☐ NSAID ☐ Iodine ☐ Shellfish ☐ Metals ☐ Tape ☐ Latex

Other Allergies: _____

Medications/Vitamins/Supplements:

Name	Dosage/Strength	Frequency

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MEDICAL HISTORY

- ☐ Anemia
- ☐ Cancer; Type_____
- ☐ Cardiac Disease
- ☐ Chronic Renal Disease
- ☐ Congestive Heart Failure
- ☐ COPD
- ☐ Diabetic: Insulin / Medication / Diet / Exercise
- ☐ Hypertension
- ☐ Kidney Disease
- ☐ M.I. (History of Heart Attack)
- ☐ Obesity
- ☐ Osteoarthritis
- ☐ Osteoporosis
- ☐ Peripheral Vascular Disease
- ☐ Rheumatoid Arthritis
- ☐ Stroke
- ☐ Tuberculosis
- ☐ Other: _____

SURGICAL HISTORY

- ☐ Hernia Repair
- ☐ Knee Replacement: Left / Right
- ☐ Hip Replacement: Left / Right
- ☐ Leg Bypass: Left / Right
- ☐ CABG (Coronary Artery Bypass Grafting)
- ☐ Appendectomy
- ☐ Gallbladder Surgery
- ☐ Vascular Surgery
- ☐ Foot Surgery: Left / Right
- ☐ Ankle Surgery: Left / Right
- ☐ Other: _____

_____

SOCIAL HISTORY

Alcohol Use: ☐ Never ☐ ≤Monthly ☐ Weekly ☐ Daily ☐ In Recovery

Smoking status: ☐ Never ☐ Former ☐ Current, ____ packs/day

Secondhand Smoke Exposure: ☐ Yes ☐ No

Use of Recreational Drugs: ☐ No ☐ Yes, Type/ Frequency _____

Exercise: ☐ Never ☐ ≤Monthly ☐ 1-2x/Week ☐ ≥3-4x/Week

FAMILY MEDICAL HISTORY (Circle all that apply)

High Blood Pressure: Father | Mother | Brother | Sister
Diabetes: Father | Mother | Brother | Sister
Stroke: Father | Mother | Brother | Sister
Heart Disease: Father | Mother | Brother | Sister
Kidney Disease: Father | Mother | Brother | Sister
Cancer: Father | Mother | Brother | Sister
Other: _____

_____

Thyroid Disorder: Father | Mother | Brother | Sister
Osteoporosis: Father | Mother | Brother | Sister
Premature Menopause: Father | Mother | Brother | Sister
Mental Illness: Father | Mother | Brother | Sister
Arthritis: Father | Mother | Brother | Sister
Asthma/Allergies: Father | Mother | Brother | Sister

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ARE YOU EXPERIENCING ANY OF THE FOLLOWING?

CONSTITUTIONAL SYMPTOMS

- ☐ Generally in good health
- ☐ Unexplained weight gain or loss
- ☐ Loss of appetite
- ☐ Fever or chills
- ☐ Night sweats/Hot flashes
- ☐ Fatigue

EYES

- ☐ Blurred or double vision
- ☐ Diabetic Eye Exam

EARS / NOSE / MOUTH / THROAT

- ☐ Hearing loss or ringing
- ☐ Earaches or drainage
- ☐ Chronic sinus problems or rhinitis
- ☐ Recurrent nose bleeds
- ☐ Bleeding gums
- ☐ Sore throat or voice changes (hoarseness)
- ☐ Hay fever

CARDIOVASCULAR

- ☐ Heart Problem
- ☐ Chest pain or angina pectoris
- ☐ Palpitation (fast or irregular heartbeat)
- ☐ Shortness of breath while walk/ lying flat
- ☐ Swelling of feet, ankles, or hands
- ☐ High blood pressure

RESPIRATORY

- ☐ Chronic or frequent coughs
- ☐ Spitting up blood
- ☐ Shortness of breath
- ☐ Asthma or wheezing

GENITOURINARY

- ☐ Frequent urination
- ☐ Burning or painful urination
- ☐ Blood in urine
- ☐ Urination at night (>1x / night)
- ☐ Incontinence or dripping
- ☐ Decrease in urine stream
- ☐ Kidney stones
- ☐ Slow to start/stop urination

MUSCULOSKELETAL

- ☐ Joint pain
- ☐ Joint stiffness or swelling
- ☐ Back pain

NEUROLOGICAL

- ☐ Frequent or recurring headaches
- ☐ Lightheaded or dizzy
- ☐ Convulsion or seizures
- ☐ Numbness or tingling sensations
- ☐ Paralysis
- ☐ Memory loss or confusion

PSYCHIATRIC

- ☐ Nervousness
- ☐ Depression / Anxiety/ Panic
- ☐ Insomnia

ENDOCRINE

- ☐ Thyroid disease
- ☐ Diabetes
- ☐ Other glandular/ hormone problem

HEMATOLOGIC / LYMPHATIC

- ☐ Bleeding or bruising easily
- ☐ Anemia

GASTROINTESTINAL

- ☐ Heart Burn
- ☐ Change in bowel movements
- ☐ Nausea or vomiting
- ☐ Diarrhea
- ☐ Painful bowel movements
- ☐ Constipation
- ☐ Rectal bleeding or blood in stool
- ☐ Abdominal pain
- ☐ Peptic Ulcer
- ☐ Trouble swallowing

ALLERGIC / IMMUNOLOGIC

- ☐ Reactions to food or drugs
- ☐ Seasonal allergies

OTHER

- ☐ Flu Shot

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Patient Record of Disclosure

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

I wish to be contacted in the following manner (check all that apply):

Home/Cell Phone Call

- ☐ Ok to leave a detailed message with info
- ☐ Leave message with call back number only
- ☐ Do not leave a message

Written Communication

- ☐ Ok to mail home address
- ☐ Ok to mail work address
- ☐ Ok to fax to _____
- ☐ Do not send written communication

Work Phone Call

- ☐ Ok to leave a detailed message with info
- ☐ Leave message with call back number only
- ☐ Do not leave a message

Access To your Foundation Foot and Ankle Specialists electronic medical records are available through the patient portal

Family/Friends Contacts to Release Medical Information:

Name: _____ Relationship: _____

Phone#: _____

Name: _____ Relationship: _____

Phone#: _____

BY MY SIGNATURE BELOW, I HEAR BY AUTHORIZE FOUNDATION FOOT AND ANKLE PLLC, ITS PROVIDERS, AND STAFF TO RELEASE INFORMATION AS INDICATED ABOVE AND TO THE ABOVE PEOPLE THAT MAY INQUIRE ABOUT MY TREATMENT, LAB RESULTS, PRESCRIPTIONS, AND OTHER HEALTH INFORMATION. I UNDERSTAND THAT THIS AUTHORIZATION REMAINS VALID UNLESS RESCINDED IN WRITING.

Patient Name: _____

Patient Signature: _____ Date: _____

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Acknowledgement of Receipt of Notice of Privacy Practices

I have received a copy of the Foundation Foot and Ankle Specialists Notice of Privacy Practices that describes how my health information is used and shared. I understand Foundation Foot and Ankle Specialists have the right to change this notice at any time.

My signature below affirms my acknowledgement that I have been provided with a copy of the notice of privacy practices.

Patient Name: _____

Patient Signature: _____ Date: _____