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

☐ Other __________

Race: ☐ American Indian/Alaska Native ☐ Asian Ethnicity: ☐ Hispanic/Latino

☐ African American ☐ Hawaiian/Pacific Islander ☐ White ☐ Not Hispanic/Latino

Preferred Language (if not English): ____________________

Emergency Contact: __________________________ **Relationship:** __________________

Home/Cell Phone: ______________________

Spouse or Legal Guardian

Name: ____ Date of Birth: ______________

Social Security#: ____________________ Sex: ☐ Male ☐ Female ☐ Other

Cell Phone: ________________________ Email: ______________________________

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

Address: ____________________________ City: __________________ Zip: __________

Home 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: ___________________

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.

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CONSENT FOR TREATMENT

TO THE PATIENT: You have the right, as a patient, to be informed about your condition and the recommended surgical, medical or diagnostic procedure to be used so that you may make the decision whether or not to undergo any suggested treatment or procedure after knowing the risks and hazards involved.

This consent provides us with your permission to perform reasonable and necessary medical examinations, testing, and treatment. By signing below, you are indicating that you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended. The consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services.

You have the right to discuss the treatment plan with your podiatrist about the purpose, potential risks and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommended by your health care provider, we encourage you to ask questions.

CONSENT TO TREAT

I voluntarily request a podiatrist and other health care professionals as may be necessary, to perform medical examinations, testing and treatment that are necessary and appropriate for the condition which has brought me to seek care at this practice, and within the standard of care for such condition.

I request and give consent to my physician to provide and perform such medical/surgical care, tests, procedures, x-ray examinations or other imaging, physical therapy, laboratory tests, drugs and other services and supplies as my physician, in his/her professional judgment, deems necessary or beneficial. I acknowledge that no representations, warranties or guarantees as to the results or cures have been made to me or relied upon by me. No guarantees have been made to me concerning the outcomes of treatments or examinations at Foundation Foot and Ankle Specialists, PLLC.

PHOTOGRAPH AND AUDIO OR VISUAL RELEASE

During the visit, photographs may be taken, and audio/visual footage may be recorded. we may use such photos/footage on the practice website in communication and promotional material outlining our services. If you do not want the use of imagery or recordings in which you are featured, please inform of in writing before or during your visit.

RELEASE OF MEDICAL INFORMATION AND AUTHORIZATION TO PAY INSURANCE BENEFITS:

I 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 medical/surgical/demographic 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, and their providers from all legal responsibility that may arise from disclosure of my records as provided by this paragraph.

Further in response to any reasonable request for cooperation, I agree to cooperate with such physician and clinic in any attempts by such physician and clinic to pursue such claim, chose in action or right against my insurers and/or employee healthcare plan, including, if necessary, bring suit with such physician and clinic against such insurers and/or employee health care plan in my name but at such physician and clinic's expense.

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FINANCIAL AGREEMENT:
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. this assignment will remain in effect until revoked by me in writing.

CONTACT RELEASE:
i understand and acknowledge by my signature below that by providing my landline/cell phone numbers and email address, that i give express authorization to contact me at the phone numbers and email address I provided. This express authorization also applies to any landline/cell phone number or email address I may acquire in the future. I understand and give consent to provide important information regarding any outstanding balances or appointment reminders and any other information by using electronic and automated technology with the contact information i provided.

I certify that I have read and fully understand the above statements, had the opportunity to ask questions and seek legal counsel, and consent fully and voluntarily to its contents.

Name: ____

Signature: ____________________________________ Date: _________________________

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Patient Health Questionnaire

Patient Name: ____________________

Reason for Today's Visit: ____________________

Referred By: ____________________

Primary Care Physician: ____________________ Last Seen by PCP: ____________

PCP Phone#: ____________________

Weight (lbs) ____________ Height ____________ Shoe Size ____________

Pharmacy (Name and Address): ____________________

Pharmacy Phone#: ____________________

Allergies (check all that apply): ☐ NONE ☐ Penicillin ☐ Sulfa ☐ Codeine ☐ NSAID ☐ Iodine ☐ Shellfish ☐ Metals ☐ Tape ☐ Latex

Other Allergies: ____________________

Medications/Vitamins/Supplements:

Name	Dosage/Strength	Frequency

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MEDICAL HISTORY ☐ NONE

- ☐ Anemia
- ☐ Cancer; Type______________________________
- ☐ Heart Disease
- ☐ Kidney Disease
- ☐ Kidney Stones
- ☐ Congestive Heart Failure
- ☐ COPD
- ☐ Diabetic: Type I / Type II
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ M.I. (History of Heart Attack)
- ☐ Obesity
- ☐ Osteoarthritis
- ☐ Osteoporosis
- ☐ Peripheral Vascular Disease
- ☐ Rheumatoid Arthritis
- ☐ Stroke
- ☐ Thyroid Disease
- ☐ Tuberculosis
- ☐ Other: ____________________________

SURGICAL HISTORY ☐ NONE

- ☐ Hernia Repair
- ☐ Knee Surgery: Left / Right
- ☐ Hip Surgery: 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 ☐ Rarely ☐ Occasional ☐ Weekends ☐ 1-2 Drinks/Day ☐ >2 drinks/day ☐ In Recovery

Tobacco Use: ☐ Never ☐ Former ☐ Current, ____ packs/day

Use of Recreational Drugs: ☐ No ☐ Yes: Type/ Frequency ___________________________

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

FAMILY MEDICAL HISTORY (Check all that apply)

Mother: ☐ High Blood Pressure ☐ Diabetes ☐ Stroke ☐ Heart Disease ☐ Kidney Disease ☐ Cancer ☐ Osteoporosis ☐ Thyroid Disease ☐ Mental Illness ☐ Arthritis ☐ Asthma

Father: ☐ High Blood Pressure ☐ Diabetes ☐ Stroke ☐ Heart Disease ☐ Kidney Disease ☐ Cancer ☐ Osteoporosis ☐ Thyroid Disease ☐ Mental Illness ☐ Arthritis ☐ Asthma

Sibling: ☐ High Blood Pressure ☐ Diabetes ☐ Stroke ☐ Heart Disease ☐ Kidney Disease ☐ Cancer ☐ Osteoporosis ☐ Thyroid Disease ☐ Mental Illness ☐ Arthritis ☐ Asthma

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ARE YOU EXPERIENCING ANY OF THE FOLLOWING? ☐ None

CONSTITUTIONAL SYMPTOMS

- ☐ Unexplained weight gain or loss
- ☐ Loss of appetite
- ☐ Fever or chills
- ☐ Sweats/Hot flashes
- ☐ Fatigue

EYES

- ☐ Blurred or double vision
- ☐ Contacts
- ☐ Cataracts
- ☐ Glaucoma
- ☐ Irritation
- ☐ Redness
- ☐ Icterus/Yellow eyes
- ☐ Color Blindness
- ☐ Eye Drainage

EARS / NOSE / MOUTH / THROAT

- ☐ Hearing loss
- ☐ Ringing
- ☐ Ear drainage
- ☐ Runny Nose/Congestion
- ☐ Nose bleeds
- ☐ Sinus Pain
- ☐ Sore throat
- ☐ Voice changes (hoarseness)

CARDIOVASCULAR

- ☐ Shortness of breath (Dyspnea)
- ☐ Chest pain (Angina pectoris)
- ☐ Exertional chest pain/discomfort
- ☐ Palpitation
- ☐ Irregular heartbeat
- ☐ Fainting (Syncope)
- ☐ Difficulty breathing lying flat
- ☐ Swelling of feet, ankles, or hands
- ☐ Calf pain when walking

RESPIRATORY

- ☐ Chronic or frequent coughs
- ☐ Spitting up blood (Hemoptysis)
- ☐ Shortness of breath on exertion
- ☐ Asthma
- ☐ Wheezing
- ☐ Sputum

GENITOURINARY

- ☐ Frequent urination
- ☐ Painful urination (Dysuria)
- ☐ Blood in urine (Hematuria)
- ☐ Urination at night (>1x / night)
- ☐ Incontinence or dripping
- ☐ Decrease in urine stream
- ☐ Hard to start/keep urination

MUSCULOSKELETAL

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

NEUROLOGICAL

- ☐ Headaches
- ☐ Lightheaded or dizziness
- ☐ Convulsion or seizures
- ☐ Vertigo
- ☐ Tremors
- ☐ Numbness or tingling sensations
- ☐ Paralysis
- ☐ Muscle weakness
- ☐ Memory loss or confusion
- ☐ Speech problems
- ☐ Coordination problems
- ☐ Walking problems

GASTROINTESTINAL

- ☐ Heart Burn/Reflux
- ☐ Indigestion (Dyspepsia)
- ☐ Change in bowel movements
- ☐ Nausea or vomiting
- ☐ Diarrhea
- ☐ Constipation
- ☐ Rectal bleeding or blood in stool
- ☐ Abdominal pain
- ☐ Peptic Ulcer
- ☐ Trouble swallowing (Dysphagia)
- ☐ Painful swallowing (Odynophagia)

PSYCHIATRIC/BEHAVIORAL

- ☐ ADHD
- ☐ Depression
- ☐ Anxiety
- ☐ Insomnia
- ☐ Bipolar

ENDOCRINE

- ☐ Temperature Intolerance
- ☐ Excessive urine (Polyuria)
- ☐ Excessive thirst (Polydipsia)
- ☐ Overeating/Cravings (Polyphagia)
- ☐ Poor Wound healing
- ☐ Other glandular/ hormone problem

HEMATOLOGIC / LYMPHATIC

- ☐ Bleeding
- ☐ Easy bruising
- ☐ Lymphadenopathy

ALLERGIC / IMMUNOLOGIC

- ☐ Reactions to food or drugs
- ☐ Seasonal allergies
- ☐ Hay fever

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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: ________________________