Dr. Stacey Paukovitz, DPM, MA, FACFAS

Patient Name: _____ Date of Birth: _____ Sex: _____

Address: _____City, state, zip: _____

Cell phone: _____ Home phone: _____Work Phone: _____

Email: _____ S S # : _____

Preferred method of appointment confirmation: ___ Phone ___ Text ___ Email

How were you referred to us today? _____

Primary Care Doctor: _____ Town: _____

Emergency Contact : _____ Emergency Contact # _____ Relationship:_____

Pharmacy Name : _____ Street : _____ City : _____

Race :
___American Indian / Alaskan Native
___Asian
___Black / African American
___ White
___ Native Hawaiian/Pacific Islander

Ethnicity :
___ Hispanic/Latino
___ NOT Hispanic/Latino

Preferred Language : __ English __ other : _____

Insurance Information

Primary Insured's Name: _____ Primary Insured's DOB: _____

Relationship to Patient Policyholder: _____Insurance Company: _____

Insurance ID#: _____ Group ID#: _____

Specialist Copay : _____

Private Insurance Assignment of Benefits
I, the undersigned, authorize payment of medical benefits to High Performance Foot & Ankle for any services furnished to me. I understand that I am financially responsible for any amount not covered by any contract, I also authorize you to release my information to my insurance company or their agent, information concerning health care, advice, treatment or supplies provided to me. This information will be used for purposes of evaluation and administrating claims or benefits.

Patient Financial Responsibility
I acknowledge full financial responsibility for services rendered by Stacy Paukovitz, DPM. I agree that if this account is turned over for collections, all costs (including reasonable collections fees and court costs) will be added to the outstanding balance. I have read and fully understand the above consent for treatment and financial responsibility.

Patient Signature_____ Date ____/____/_____

Patient Name: _____ Date of Birth: _____ Acct # _____

List of Current Medications

_____ _____ _____ _____

_____ _____ _____ _____

List of Current Allergies

_____ _____ _____ _____

Height _____ **Weight**_____ **Shoe Size**_____

SMOKING STATUS: **Are you a Tobacco User:** ☐ Yes ☐ No

☐ Current Every day Smoker ☐ Current Some Day Smoker ☐ Heavy Tobacco Smoker ☐ Light Tobacco Smoker

☐ Former Smoker ☐ Never Smoker No. of Years: _____ Pack/Day: _____ Date of Quit: _____

Alcohol Use: ☐ Non- Drinker ☐ Social Drinker ☐ Heavy Alcohol Consumption ☐ Recovering Alcoholic **Drug Use:** ☐ Yes ☐ No

List of all Previous Surgeries/Hospitalizations

_____ _____ _____ _____

Past Medical History Check (√) conditions which you have or have had in the past year.

☐ Alcoholism	☐ Epilepsy	☐ Liver Disease	☐ Thyroid Disease
☐ Anemia	☐ Glaucoma	☐ Migraines	☐ Tuberculosis
☐ Arthritis	☐ Gout	☐ Multiple Sclerosis	☐ Other _____
☐ Asthma	☐ Heart Disease	☐ Prostate disease	
☐ Bleeding Disorder	☐ Hepatitis	☐ Rheumatic Arthritis	
☐ Bronchitis	☐ High Cholesterol	☐ Scarlet Fever	
☐ Cancer_____	☐ HIV/AIDS	☐ STD	
☐ COPD	☐ Hypertension	☐ Stroke	
☐ Diabetes	☐ Kidney Disease		

(Circle the appropriate letter for Father, Mother, Brother, Sister, and Children)

Arthritis	M	F	S	B	C	Thyroid Dz.	M	F	S	B	C
Asthma	M	F	S	B	C	Kidney Dz.	M	F	S	B	C
Angina	M	F	S	B	C	Heart Dz.	M	F	S	B	C
Hypertension	M	F	S	B	C	Cancer	M	F	S	B	C
Stroke	M	F	S	B	C	Seizures	M	F	S	B	C
Diabetes	M	F	S	B	C	Hepatitis	M	F	S	B	C
						Other: _____					

ROS Check (√) symptoms you currently have or have had in the past year.

CONSTITUTIONAL
- ☐ recent change in weight
- ☐ fever
- ☐ chills
- ☐ feeling tired or poorly
- ☐ weakness

CARDIOVASCULAR
- ☐ rapid or irregular heartbeat
- ☐ chest pain
- ☐ edema of feet or legs
- ☐ cold hands or feet
- ☐ calf claudication

RESPIRATORY
- ☐ cough
- ☐ wheezing
- ☐ difficulty breathing
- ☐ shortness of breath

GASTRONINTESTINAL
- ☐ anorexia
- ☐ light colored bowel movement
- ☐ nausea
- ☐ vomiting
- ☐ diarrhea
- ☐ abdominal pain
- ☐ abnormal liver function tests

MUSCULOSKELETAL
- ☐ arthritis
- ☐ back pain
- ☐ joint pain
- ☐ joint stiffness
- ☐ gout
- ☐ muscle aches
- ☐ muscle cramps

NEUROLOGICAL
- ☐ seizures
- ☐ weakness
- ☐ numbness
- ☐ tingling
- ☐ burning sensation

DERMATOLOGIC
- ☐ rash
- ☐ itching
- ☐ dry skin
- ☐ mass
- ☐ bruising
- ☐ hives
- ☐ flushing

Other:

_____

_____

_____

PATIENT CONSENT FORM

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (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 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.

You have informed me of your *Notice of Privacy Practices* containing a more complete description of the users. I have been given the right to review such *Notice of Privacy Practices* prior to signing this consent. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and I may contact this organization at any time at the address below 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 required to agree to my requested restrictions, but if you do agree that you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at the time, except to the extent that you have taken action relying on this consent.

Patient Name: _____

Signature:_____

Relationship to Patient: _____

Date: ____/____/____

AUTHORIZATION TO RELEASE INFORMATION TO:

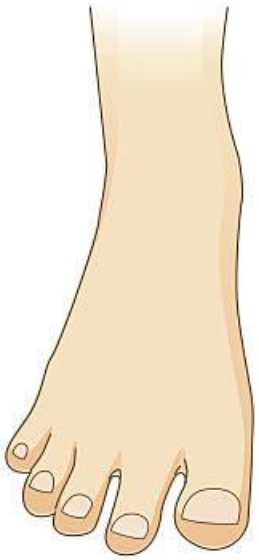
1) _____

2) _____

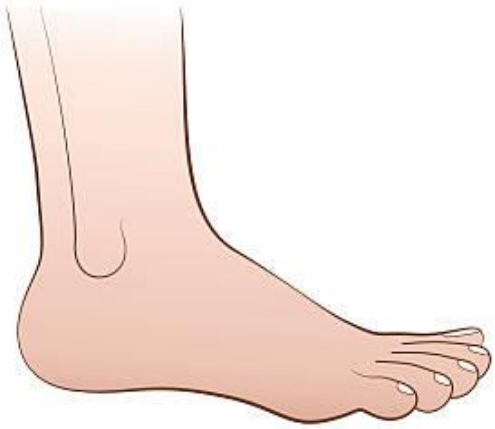
WHERE DO YOU HURT? (MARK) _____

LEFT or RIGHT (CIRCLE)

DESCRIPTION: _____



MEDIAL VIEW
(inside)



LATERAL VIEW
(outside)