HANSEN
FOOT & ANKLE

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PATIENT INFORMATION **Date: ______________________**

Name: ____ SS#: ________________________
Last First middle initial

Address: _______________________________________ City/State/Zip: ___________________________

Email: _______________________________________

Home #: _____________________ Cell #: _________________ Work #: _______________________

Gender: ☐ M ☐ F Age: _______ Birthdate: _______________ ☐ Single ☐ Married ☐ Widowed

# of children: _____ Race: ☐ Caucasian ☐ Latino ☐ Black ☐ Asian ☐ Prefer not to say ☐ Other _______

In case of emergency notify: __________________ Relationship: ____________ Phone: __________________

Patient Employer: ____________________________ Occupation: _________________________________

Primary Care Physician/Clinic: ____

City: ______________ State: __________ Phone: ____

Whom may we thank for referring you to our office: ☐ Google ☐ Facebook ☐ Insurance Website ☐ Sign

☐ Friend Referral (Name): ____

☐ Physician Referral (Name/Address/Phone): ____

Insurance Information: - * We Do Not Accept Medicaid as a Primary OR Secondary*****

Primary Insurance: ______________________ ID #: ___________________ Group #: ____________

Subscriber Name ______________________________ Birthdate: _______________________

Relation to Patient: ________________________________ Employer: ______________________________

Secondary Insurance: ______________________ ID #: ___________________ Group #: ____________

Subscriber Name: _____________________________ Birthdate: ________________________

If work/auto related injuries, DOI/ L&I #: ____

Assignment and Release: The above named doctor may use my health care information and may disclose such information to the patients Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

____ ____________________
****Signature of Patient, Parent/Guardian or Personal Representative** Date

Print name of Patient, Parent or Guardian ____

Acknowledgement of receipt of Notice of Privacy Practices: I acknowledge that I was provided the Notice of Privacy Practices and that I have read and understand it.

____ __________________

Signature of Patient, Parent/Guardian or Personal Representative Date

(The signature line is preceded by two asterisks: "**Signature of Patient, Parent/Guardian or Personal Representative".)

What is the nature of your foot complaint:

____

____

What have you tried to treat your condition?

____

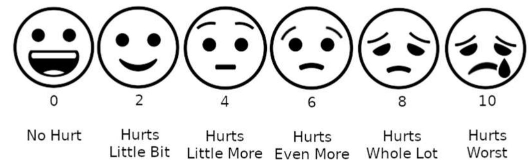
____

When does it hurt the most? (morning, after activity, at rest, etc.…)

____

Approximately when did the condition start? ____

How would you rate your foot pain today? (circle a smiley face)



How would you describe your pain? (circle all that apply below)

Burning Dull Sharp Aching Throbbing Other _________

Do you smoke: ______ **How much:** ______ **Drink Alcohol:** ______**How much** (circle one): **rarely/occasionally/daily**

How many servings of caffeine do you consume in a day? ______________

Height: _______ **Weight:** _______ **Shoe Size:** ______ **Width** (circle one) : **Narrow/Regular/Wide**

Have you had any serious illness or operations? ☐ No ☐ Yes

If yes, please describe: ____

Do you have low back pain? ☐No ☐ Yes

Have you tested positive for HIV? ☐ No ☐ Yes **Are you subject to profuse bleeding?** ___ No ___ Yes

Please check if you have had any of the following:

☐ Anemia	☐ High Cholesterol
☐ Asthma	☐ Immune Deficiency
☐ Arthritis	☐ Kidney Problems
☐ Cramps in feet/legs	☐ Liver Problems
☐ Diabetes, Insulin	☐ Numbness in feet/legs
☐ Diabetes, Orally Controlled	☐ Swelling in ankles/feet
☐ Gout	☐ Thyroid Problems
☐ Heart Problems	☐ Tuberculosis
☐ Hepatitis	☐ Varicose Veins
☐ High Blood Pressure	☐ Other __________

Allergies:

- ☐ No Known Drug Allergies
- ☐ Adhesive Tape
- ☐ Contrast Dye
- ☐ Iodine
- ☐ Latex
- ☐ Penicillin
- ☐ Other Medication: ____________________

Please List Medications You Are Currently Taking (include dosage):

____

____

____

Family History (please indicate mother or father's side of family):

- ☐ Diabetes
- ☐ High Blood Pressure
- ☐ Heart Disease
- ☐ Bleeding disorder
- ☐ Anesthesia problems
- ☐ Cancer: (what kind?) ______________________
- ☐ Other: __________________________________

Which Foot is Painful (circle one) : Right Left Bilateral

Please Circle Area That Is Painful: