# Patient Profile

Patient Name:_____ Date of Birth:___/___/___

Address:_____ Social Security #_____

City,State,Zip_____ Marital Status:()Married()Single()Other

Phone:_____()Home()Cell()work Phone:_____()Home()Cell()work

Email:_____ Pharmacy Name Address:_____

EMPLOYMENT: Referring Physician:_____

()Employed()Retired()Other Primary Physician:_____

Occupation:_____ Emergency Contact:_____

Employer:_____ Phone:_____

INSURANCE GUARANTOR (Who is the policy holder)

() Same as patient

If not same as patient

Name_____ Date of Birth:___/___/___

Address:_____ Social Security #_____

City,State,Zip_____ Relationship()Spouse ()Parent ()Other

# Pittsburgh Foot and Hand Center, P.C.

## HIPPA Notification

Acknowledgement of Receipt of Notice of Privacy Practices

Pittsburgh Foot and Hand Center,PC.reserves the right to modify the privacy practices outlined in the notice.

Patient Name:_____

Patient Signature:_____Date:_____

Signature of Patient Representative:_____Date:_____

Required if the patient is a minor or an adult who is unable to sign this form

Relationship of Patient Representative:_____

Attempt to Obtain Acknowledgement of Receipt of Notice of Privacy Practices

An attempt was made to obtain an Acknowledgement of Receipt of Notice of Privacy Practices on _____

The acknowledgement was not obtained because:

- The patient was undergoing emergency treatment
- The patient declined to sign acknowledgement
- Other_____

Signature of Staff:_____Date:_____

## *Personal Health History*

Patient Name: _____

Chief Complaint: _____

Reason you are being seen: _____

Date of Onset: _____

Allergies – Please included Reaction: _____ ( ) None

_____

Medications: Name Dose Include over the counter and Herbal

_____

_____

## *Past Medical History*

Have you ever been diagnosed with:

| Yes | |
|---|---|
| | cancer Type: |
| | heart disease |
| | stroke |
| | high blood pressure / hypertension |
| | high cholesterol / hyperlipidemia |
| | congestive heart failure |
| | ENT disorder |
| | hearing impairment |
| | Skin disease / psoriasis |
| | Musculoskeletal disorder |
| | arthritis |
| | osteoporosis |
| | chronic back pain |
| | growth developmental disorder |
| | endocrine disorder |
| | diabetes |
| | thyroid disease |
| | kidney disease |
| | respiratory disease |
| | asthma |

| Yes | |
|---|---|
| | bronchitis |
| | chronic lung disease |
| | TB |
| | neurological disorder |
| | seizures |
| | epilepsy |
| | polio |
| | multiple sclerosis |
| | chronic headaches |
| | psychiatric condition |
| | depression |
| | anxiety |
| | suicide attempt |
| | anemia |
| | bleeding |
| | blood clots |
| | phlebitis |
| | blood transfusion |
| | other |

## *Past Surgical History*

Previous Surgeries: _____

_____

_____

## *Family History: Has Anyone in your family been diagnosed with:*

| | | | | |
|---|---|---|---|---|
| Cancer | Yes | No | Unknown | Relationship_____ |
| Heart Disease | Yes | No | Unknown | Relationship_____ |
| Diabetes | Yes | No | Unknown | Relationship_____ |
| Respiratory Disease | Yes | No | Unknown | Relationship_____ |
| Blood Clots | Yes | No | Unknown | Relationship_____ |
| Psychological/Social Disorder | Yes | No | Unknown | Relationship_____ |

## *Risk Factors:*

Do you use tobacco: Yes No Type: ( ) Cigarettes ___PPD
( ) Cigars / Pipes ___# per week
( ) Snuff / Chew ___# per day

Alcohol: Yes No ( ) Occasionally ( ) Weekly ( ) Daily

Caffeine: Yes No _____# of drinks per day

Drug Usage: Yes No Type:_____

Exercise: Yes No _____ # of time per week Type:_____

Height:_____ Weight:_____

## *Review Of Systems:*

### *Are you currently experiencing any of the following? Please circle*

| | | |
|---|---|---|
| Fever / Chills / Sweats | Diarrhea | Seizures |
| Loss of appetite | Constipation | Tremors |
| Fatigue | Change in bowel habits | Dizziness |
| Blurred vision /Double vision | Abdominal pain | Depression |
| Eye irritation / Eye discharge | Jaundice | Anxiety |
| Vision loss | Bloody stool / Black tarry stools | Memory loss |
| Earache | Incontinence | Mental disturbance |
| Ringing of ears | Burning with urination | Suicidal thoughts |
| Decreased hearing | Blood in urine | Hallucinations / Paranoia |
| Nasal congestion/ discharge | Frequent urination | Cold intolerance / Heat intolerance |
| Sore throat | Back pain | Excessive thirst / hunger |
| Chest pain | Joint pain / Joint swelling | Weight change |
| Palpitations | Muscle cramps | Abnormal bruising |
| Fainting | Stiffness | Abnormal Bleeding |
| Difficultly breathing when lying flat | Arthritis | Enlarged lymph nodes |
| Shortness of Breath on exertion | Rash / Itching / dry skin | HIV |
| Cough | Skin Lesions | Immune disorder |
| Excessive sputum / Bloody sputum | Paralysis | Persistent infection |
| Wheezing | Weakness | Hay fever |
| Nausea / Vomiting | Numbness / Tingling | |

# Pittsburgh Foot and Hand Center P.C

## Financial Responsibility:

I understand and acknowledge that the ultimate financial responsibility to pay for the medical services provided to me by the Pittsburgh Foot and Hand Center P.C. (PFHC) is mine. This includes but is not limited to insurance co-payments, deductibles, and non covered services. I authorize PFHC to bill my insurance carrier and request such payments be made directly to PFHC. I certify that the information that I have given about my insurance coverage or other payment source is correct.

## Assignment of Benefits:

I agree to assign to PFHC as beneficiary the portion of the proceeds or benefits pf any insurance policy, benefit plans or claims against any third party necessary to pay PFHC bills for my medical services and treatment. In the event that I retain an attorney to prosecute my claim, I will instruct the attorney to protect and pay fully PFHC bills first out of any settlement or judgment proceeds.

## Release of Information:

I authorize PFHC to release my medical information as required by the insurance carrier or benefit plan for payment. I authorize PFHC to release medical information regarding my medical evaluation and treatment for my work related injury to my workers compensation carrier, its duly authorized representative and others, including my case managers and vocational rehabilitation counselors. I authorize release of work status to my employer.

**Patient Signature:** _____ **Date:** _____

## Medicare Authorization:

**Medicare ID #** _____

I request that payment of authorized medical benefits be made to either to me or on my behalf to PFHC for any services furnished my by PFHC. I authorize any holder of medical information about me to release to Centers for Medicare Services and its agents any information needed to determine these benefits or the benefits payable for related services.

**Patient Signature:** _____ **Date:** _____

## Workers Compensation / Auto Patients:

Was this the result of an accident or injury? Yes No Type of Claim: WC Auto Claim #_____
Date of Accident or Injury: ____-____-____ Place of Accident or Injury:_____
Injury Description:_____
Are you presently working: Yes No If no last date worked:____-____-____
Insurance Name:_____ Phone: (____)____-____
Address:_____City:_____State:_____Zip_____
Contact Person / Agent's Name:_____ Phone: (____)____-____

Responsible Employer (Workers Comp Only)_____Phone: (____)____-____
Address:_____City:_____State:_____Zip_____
Contact Person:_____

**Patient Signature:** _____ **Date:** _____