RAY FOOT & ANKLE CENTER

Mark J. Ray, DPM
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PATIENT INFORMATION SHEET

(Revised 10/2014)

Patient's Last Name ______________________ First Name __________________ Middle Initial _____

SS# _____-_____-_______ Date of Birth _____-_____-______ Age _____ Sex F M

Address ____________________________________ City ________________ State ____ Zip _______

Home Phone _____-______-______ Cell Phone _____-______-______ Other Phone _____-______-_____

Marital Status: (Circle one) --- Single Married Divorced Widowed Separated

Email: _____________________@______________ Ethnicity: Caucasian__ Hispanic__ African __ Other __

Employer:________________________________ Phone: _____-_____-_______ Retired ☐

What is your occupation __________________________ Does it involve standing ___ or sitting ___

Primary Care Physician ___________________________ Date Last Seen: _____/_____/_______

Did you have a pneumonia shot ___yes ___no Have you received your flu shot for 2014/2015 season ___yes ___no

Please List Name(s)/Relationship(s) of people that we may speak w/regarding your health information on line below ---

Name(s) & Relationship____

Emergency contact: ______________________________________ Phone # _____-_____-_______

PHARMACY-(Inc Address &/or Phone) ____

VITAL SIGNS: **Height** ___'____" **Weight** _________ lbs. **Blood Pressure** ________ / ________

DESCRIBE THE REASON YOU ARE BEING SEEN TODAY - ________________________________

How long has this bothered you? __________________________ Pain level w/10 being most severe - _____ / 10

What treatment(s) have you tried for this condition? _______________________________________

How did you hear about Dr. Ray? _____PCP Referral _____Friend _____Sign _____Radio _____Internet _____Other

INSURANCE INFO

Insured's Name if different than patient: ______________________________ DOB ____/____/_______

Relationship to patient: ____________________ *We will need a copy of your insurance card*

MEDICAL INFORMATION

LIST ALL MEDICATIONS YOU ARE TAKING I am **not** taking any medications ______	DOSE		LIST ANY DRUG ALLERGIES No known drug allergies _____	TYPE OF REACTION

Continue to 2nd page

PATIENT NAME: ______________________________ **Date of Birth** ____/____/_____

History and Physical

Medical History: ☐ Alcoholism ☐ Blood disorders ☐ Circulation problems ☐ Musculoskeletal ☐ Breathing issues
☐ Liver ☐ Sleep apnea ☐ Gout ☐ Allergies ☐ Heart disease ☐ Asthma
☐ Heart murmur ☐ Stomach/bowel ☐ Depression ☐ Anxiety disorder ☐ Mental illness ☐ Kidney disease
☐ Blood clot ☐ High cholesterol ☐ High blood pressure ☐ Cancer ☐ Hepatitis
☐ Neuropathy *(specify)* ____________ ☐ Thyroid disease *(specify)* ____________ ☐ Diabetes (type 1, type 2)
☐ Arthritis *(specify)* ____________ ☐ other *(specify)* ____________ ☐ HIV ☐ CVA
Are you pregnant? ☐ Yes ☐ No **Are you nursing?** ☐ Yes ☐ No ☐ Skin disorders ☐ Stroke

Surgical History ☐None ☐Appendectomy ☐ C-Section ☐Angioplasty ☐Bypass ☐Cataracts ☐ Cholecystectomy
Have you ever had any surgical procedures on foot/ankle or anywhere else on your body? ☐ Yes ☐ No
If yes, please describe: ____
Do you have any artificial joints? ☐ Yes (where? ____________) ☐ No Do you have an artificial heart valve? ☐ Yes ☐ No

Social History
Do you smoke? ☐Yes ☐No If yes how many packs per day? ☐1 ☐2 ☐3 ☐4 ☐5 For how long?
Do you drink alcohol? ☐Yes, everyday (5-7 days/week) ☐Yes, occasionally/socially ☐No/Rarely

Family History Is there any family history *(blood relative)* of: *(Please indicate family member)*

☐ Alzheimer's ____________
☐ Arthritis ____________
☐ Bleeding disorders ____________
☐ Blood clot ____________
☐ Cancer ____________
☐ Cataracts ____________
☐ Circulation problems ____________
☐ Other (specify): ____________
☐ Depression ____________
☐ Diabetes ____________
☐ Emphysema ____________
☐ Heart disease ____________
☐ High Blood Pressure ____________
☐ Neurological ____________
☐ Strokes ____________

ADDITIONAL COMMENTS: ____

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PRIVACY: We will keep your information confidential/no public reporting. The phone # & address you provide will be used to correspond with you for appointments, billing, etc. We also may leave messages if you are unavailable.
The information I have supplied is correct to the best of my knowledge. I understand that I am responsible for notifying Ray Foot & Ankle Center of any & all updates to my medical history. I authorize payment of medical benefits to Dr. Mark Ray. I authorize release of any medical information necessary to process claims & for Dr. Ray's office to retrieve my medication history. I have received/read or had the opportunity to receive/read the HIPAA privacy practices notice. I also give my consent to Dr. Ray to perform any and all treatments deemed necessary towards the diagnosis & treatment of my condition(s). I am also aware that I may be responsible for any monies that are not paid by the insurance, are not a covered benefit or reflect my deductible, copayment, coinsurance, etc.

PATIENT SIGNATURE ______________________________ **DATE** ____/____/____
(Patient/Responsible Party)