Aric Swancutt DPM LLC

Patient's Information Form
(Please Print)

Date: _____

Patient Name: _____ Date of Birth: _____ Age: _____ Sex: _____
Last First MI M/F

Home Address: _____ City/State: _____ Zip: _____

		May we leave a message?	
Home Phone #:	_____	☐ Yes	☐ No
Work Phone #:	_____	☐ Yes	☐ No
Cell Phone #:	_____	☐ Yes	☐ No
Email:	_____	☐ Yes	☐ No

Primary Language: _____
Race: _____ Ethnicity: _____

Emergency Contact: _____ Relationship: _____ Phone #: _____
Primary Care Doctor: _____ Phone #: _____
Pharmacy: _____ Location: _____ Phone #: _____

Who is responsible for payment? _____ Relationship to Patient? _____
Address: _____ City/State: _____ Zip: _____ Phone #: _____
Who referred you to us? _____

Insurance Information:

Primary Insurance Company Name: _____
Address: _____ City/State: _____ Zip: _____ Phone #: _____
Insured name: _____ Date of Birth: _____ Employer: _____
Contact #: _____ Group: _____
Secondary Primary Insurance Company Name: _____
Address: _____ City/State: _____ Zip: _____ Phone #: _____
Insured name: _____ Date of Birth: _____ Employer: _____
Contact #: _____ Group: _____

Aric Swancutt, DPM

Patient Name: _____
Date of Birth: _____

Please list all medications you are currently taking (including prescriptions, over-the-counter Meds and herbal supplements):

Name	Dose	How often do you take?

Please list all prior surgeries:

Type of Surgery	Date	Type of Surgery	Date

Social history

Marital Status: ☐Single ☐Married ☐Partnered ☐Separated ☐Divorced ☐Widowed
Use of alcohol: ☐Never ☐No Longer Use ☐History of alcohol abuse
☐Current use-Type: _____ ☐Rare ☐Occasional ☐Moderate ☐Daily
Use of Tobacco: ☐Never ☐Quit – How long? Ago? _____ ☐smoke _____ Packs/day for _____ years
Use of Recreational Drugs: ☐Never ☐Quit – how long ago? _____ Type: _____
☐Current use-Type: ☐Rare ☐Occasional ☐Moderate ☐Daily
Employer: _____ Occupation: _____
How much are you on feet at work? ☐10% ☐25% ☐50% ☐75% ☐100%
Do others depend upon you for their care? ☐Children – Age(s) _____ ☐pet(s) – what kind? _____
☐Elderly or disabled family member ☐Other _____
Exercise: ☐Never ☐Rare ☐Occasional ☐Weekly ☐Several times a week ☐Daily
Types of exercise: _____

Family History

Do you have a family history of: ☐Diabetes type 1 or type 2 ☐cancer ☐heart disease
☐High blood pressure ☐stroke ☐coronary artery disease ☐Thyroid disease
☐Rheumatoid Arthritis

Your Medical History

Allergies: ☐Medications _____
☐Anesthesia _____ ☐Foods _____
☐Tape ☐Latex ☐Shellfish ☐Iodine ☐Other _____
☐None known

Have you ever had any of the following?

Acid reflux	☐Y	☐N	fibromyalgia	☐Y	☐N	Neuropathy	☐Y	☐N
anemia	☐Y	☐N	Gout	☐Y	☐N	Open sores	☐Y	☐N
arthritis	☐Y	☐N	Heart attack	☐Y	☐N	Pneumonia	☐Y	☐N
asthma	☐Y	☐N	Heart disease/failure	☐Y	☐N	Polio	☐Y	☐N
Back trouble	☐Y	☐N	hepatitis	☐Y	☐N	Rheumatic Fever	☐Y	☐N
Bladder infections	☐Y	☐N	Hiv+/aids	☐Y	☐N	Sickle cell disease	☐Y	☐N
Abnormal bleeding	☐Y	☐N	High blood pressure	☐Y	☐N	Skin disorder	☐Y	☐N
Blood clots	☐Y	☐N	Kidney disease	☐Y	☐N	Sleep apnea	☐Y	☐N
Blood transfusion	☐Y	☐N	Liver disease	☐Y	☐N	Stomach Ulcers	☐Y	☐N
Bronchitis/emphysema	☐Y	☐N	Low blood pressure	☐Y	☐N	Stroke	☐Y	☐N
cancer	☐Y	☐N	Migraine headaches	☐Y	☐N	Thyroid Disease	☐Y	☐N
Diabetes type 1 or type 2 (circle)	☐Y	☐N	Mitral Valve Prolapse	☐Y	☐N	tuberculosis	☐Y	☐N

Other Conditions: _____

Current Problem

What specific problem brings you to our office today? _____

Where is the pain/problem located? Please check all that apply.

☐right foot ☐left foot
☐right ankle ☐left ankle
☐right lower leg ☐left lower leg

How long ago did this problem first start? _____ ☐Days ☐Weeks ☐Months ☐Years

Did your pain or problem: ☐Begin suddenly ☐Gradually develop over time

How would you describe your pain? ☐No pain ☐Sharp ☐Dull ☐Aching ☐Burning
☐Radiating ☐Itching ☐Stabbing ☐Other _____

How would you rate your pain on a scale from 0 to 10? (Please check)
(No pain) ☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10 (Worst pain possible)

Since the time your pain or problem began, has it: ☐Stayed the same ☐Become worse ☐improved

What makes your pain or problem feel worse? ☐Walking ☐Standing ☐daily activities
☐resting ☐Dress shoes ☐High heels ☐Flat shoes ☐Any close toe shoe
☐Running ☐Other _____

What makes your pain or problem feel better? _____

What treatments have you had for this problem? _____

How has this problem affected your lifestyle or ability to work? _____

Was this problem caused by any injury? ☐Yes (Describe) _____ ☐No
If yes, was it a work-related injury? ☐Yes ☐No

To the best of my knowledge, I have answered the questions on this form accurately. I understand that Providing incorrect information can be dangerous to my health. I understand that it is my responsibility to inform the doctor and office staff of any chances in my medical status.

_____ _____
Print name of patient, parent, or guardian Signature

_____ _____
If other that patient, relationship to patient Date

HIPAA Compliance Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all fall disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

May we phone, email, or send a text to you to confirm appointments?

May we leave a message on your answering machine at home or on your cell phone?

May we phone, email, or send a text to you to confirm appointments?	☐ Yes	☐ No
May we leave a message on your answering machine at home or on your cell phone?	☐ Yes	☐ No
May we discuss your medical condition with any member of your family?	☐ Yes	☐ No

If YES, please name the members allowed:

_____

_____

This consent was signed by: _____

(Print name please)

Signature: _____ Date: _____

Witness: _____ Date: _____