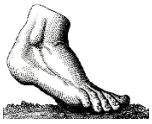
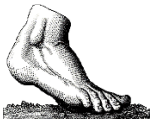




Columbus Foot & Ankle, P.C.

1013 Centre Brook Ct Ste B

Columbus, Georgia 31904

Dr. Troy D Espiritu, DPM FACFAS

Dr. Nicholas C Smith, DPM FACFAS

Patient Information

(Please Print)

Name_____ Date_____

First Middle Last

Address_____ City_____ State_____ Zip_____

Home Phone _____ Cell Phone _____ Social Security _____

Date of Birth _____ Age _____ Sex ____ Marital Status Single Married Widowed Divorced Separated

How did you find out about us? (Referral, Internet, Facebook, Friend) _____

Who is your personal physician (primary care)? _____

Where do you work? _____What is your position? _____

Employer's Address _____ Employer's Phone # _____

Person Responsible for Payment

(Please fill out if other than person above or if patient is a child)

Name _____ Relationship _____

Address _____ Home Phone _____

Employer _____ Position _____

Employer Address _____ Business Phone _____

Person we should notify in case of an EMERGENCY

Name _____ Relationship _____

Address _____ Home Phone _____

Employer _____ Position _____ Business Phone _____

Insurance Information

Insurance Company Policy # Group # Insured Social Security #

1 _____

2 _____

Name of Insured _____ Relationship _____ Date of Birth _____

We will be happy to bill your insurance company; however, payment is expected from you on the day services are rendered for supplies, co pays, and/or deductibles. Other arrangements must be made before your appointment.

I hereby give my permission to Dr. Troy Espiritu/Dr. Nicholas Smith to administer treatment and care as may be deemed accessary in the care of my foot/ankle complaints, which I have willingly solicited his help and advice. I understand that each procedure will be explained to me prior to its institution and any charge incurred will be my sole responsibility. I also understand that not all podiatry services are considered as covered services by Medicare and other insurance providers, and further that Medicare or other insurance providers could determine the services rendered in this office to be medically unnecessary. I believe these services will be of benefit to me and therefore assume full responsibility for payment.

Signed _____ Date _____

Name _____ Date _____

Medical Information

Describe your foot/ankle problem_____

_____

_____

How long has it bothered you? _____ Can you recall any type of injury? _____

Please rate your pain (circle one) 1 (mild) 2 3 4 5 (moderate) 6 7 8 9 10 (severe)

What makes the condition worse? _____

What makes the condition better? _____

Have you tried to treat this condition (soaks, pad, changing shoes, medications?) Yes No

If Yes, please list _____

Have you been treated by another doctor for this problem? Yes No If so, Who? _____ When? _____

Physician Notes _____

_____

_____

General Health Information

Current Weight _____ Height _____ Shoe Size _____

Are you currently under the care of a physician? Yes No Conditions being treated _____

Name of physician _____ Last visit _____

Are you **DIABETIC?** Yes No If so, HOW LONG have you been diabetic? _____

What is your AM blood sugar range? _____

Do you currently take INSULIN? Yes No

Do you have any problems with your liver? Yes NO If so, what? _____

Do you have any problems with your kidneys? Yes No If so, what? _____

Do you have any problems with your heart? Yes No If so, what? _____

CHECK ALL THAT YOU HAVE OR HAVE HAD A PROBLEM WITH:

____ Asthma	____ Bladder	____ Frequent Infection	____ Lung
____ Arthritis	____ Circulation	____ Gout	____ Stomach Ulcers
____ Anemia	____ Foot Ulcers	____ High Blood Pressure	____ Skin

Please list any other health problems you are aware of: _____

_____

_____

Medications

NAME	***DOSE***	***FREQUENCY***	***PRESCRIBING PHYSICIAN***
1			
2			
3			
4			
5			

Please list any non-prescription medications you take on a regular basis:

1 _____ 2 _____ 3 _____ 4 _____

Columbus Foot & Ankle, P.C.

Dr. Troy D Espiritu, DPM FACFAS Dr. Nicholas Smith, DPM FACFAS

Name: _____ Date: _____

Review of systems: Please indicate any personal history below. Although some of the questions below do not pertain specifically to your foot/ankle problem, please be as thorough as possible. This is essential for our permanent records and it allows your doctor to provide you with the most appropriate care.

Constitutional Symptoms

Good General Health Lately	NO	YES
Recent Weight Change	NO	YES
Fever	NO	YES
Fatigue	NO	YES
Headaches	NO	YES

Eyes

Eye Disease or Injury	NO	YES
Wear Glasses/Contact Lens	NO	YES
Blurred or Double Vision	NO	YES
Glaucoma	NO	YES

Ears/Nose/Mouth/Throat

Hearing Loss/Ringing	NO	YES
Earaches or Drainage	NO	YES
Chronic Sinus Problems	NO	YES
Nose Bleeds	NO	YES
Mouth Sores	NO	YES
Bleeding Gums	NO	YES
Swollen Glands in Neck	NO	YES

Cardiovascular

Heart Trouble	NO	YES
Chest Pain or Angina	NO	YES
Palpitations	NO	YES
Shortness of Breath While Walking	NO	YES
Swelling in Feet/Ankles	NO	YES

Respiratory

Chronic or Frequent Cough	NO	YES
Asthma or Wheezing	NO	YES

Gastrointestinal

Loss of Appetite	NO	YES
Nausea or Vomiting	NO	YES
Frequent Diarrhea	NO	YES
Constipation	NO	YES
Peptic Ulcers	NO	YES

Genitourinary

Frequent Urination	NO	YES
Burning or Painful Urination	NO	YES
Kidney Stones	NO	YES

Musculoskeletal

Joint Pain	NO	YES
Joint Stiffness/Swelling	NO	YES
Weakness of Muscles	NO	YES
Muscle Pain or Cramps	NO	YES
Back Pain	NO	YES
Cold Extremities	NO	YES
Difficulty in Walking	NO	YES

Integumentary

Rash or Itching	NO	YES
Foot/Leg Ulcers	NO	YES
Change in Skin Color	NO	YES
Change in Hair/Nails	NO	YES
Varicose Veins	NO	YES

Neurological

Frequent Headaches	NO	YES
Light Headed or Dizzy	NO	YES
Convulsions/Seizures	NO	YES
Numbness/Tingling	NO	YES
Tremors	NO	YES
Paralysis	NO	YES
Stroke	NO	YES

Psychiatric

Memory Loss/Confusion	NO	YES
Nervousness	NO	YES
Depression	NO	YES
Insomnia	NO	YES

Endocrine

Hormonal Problem	NO	YES
Thyroid Disease	NO	YES
Diabetes	NO	YES
Excessive Thirst/Urination	NO	YES
Heat/Cold Intolerance	NO	YES
Skin Becoming Dryer	NO	YES

Hematological/Lymphatic

Slow to Heal After Cuts	NO	YES
Bleeding/Bruising Tendencies	NO	YES
Anemia	NO	YES
Phlebitis	NO	YES

NOTES_____

_____

Reviewed By: _____ Date: _____

ALLERGIES

Please indicate all that you are allergic or sensitive to:

_____ I have NO ALLERGIES that I'm aware of.

		Reaction			Reaction
Adhesive Tape	NO YES	_____	Penicillin	NO YES	_____
Betadine	NO YES	_____	Sulfa Drugs	NO YES	_____
Codeine	NO YES	_____	Other (Please List)		_____
Demerol	NO YES	_____	_____		
Local Anesthesia	NO YES	_____	_____		

SURGICAL HISTORY

Please list **ANY AND ALL** surgeries:

	Date of Surgery		Date of Surgery
1.	_____	5.	_____
2.	_____	6.	_____
3.	_____	7.	_____
4.	_____	8.	_____

Have you ever had a BAD EXPERIENCE with anesthesia? NO YES

If yes, please describe:

_____

_____

SOCIAL HISTORY

Do you smoke? NO YES If yes, how many packs a day? _____ For how long? _____ years

Have you smoked in the past, but quit? NO YES If yes, how long ago did you quit? _____

Do you drink alcohol or beer? NO YES If yes, how much? ____1-2 a day ____1-2 a week ____ Other

Do you use any illegal drugs? NO YES If yes, please list _____

Do you participate in any physical activities on a regular basis? NO YES

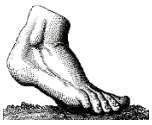
If yes, please list _____

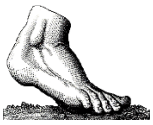
Has your foot/ankle problem interfered with your ability to perform these activities? NO YES

FAMILY HISTORY

Does anyone in your FAMILY (blood relative) have a history of:

		Relation			Relation
Bleeding Disorders	NO YES	_____	Arthritis	NO YES	_____
Circulation Problems	NO YES	_____	Bunions	NO YES	_____
Diabetes	NO YES	_____	Hammertoes	NO YES	_____
Heart Disease	NO YES	_____	Foot Ulcers	NO YES	_____
Stroke	NO YES	_____	Flat Feet	NO YES	_____
Nerve Problems	NO YES	_____	High Arches	NO YES	_____





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Phone: (706)653-5501 Fax: (706)653-5504

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read, or I have had the opportunity to read if I so choose, and understand the Notice.

Patient Name (Please Print)

Parent or Authorized Representative (if applicable)

Signature

Date