Copper Top Foot & Ankle Clinic / Copper Top Sports Medicine Clinic

Dr. Clint Vanlandingham, DPM,FNP-BC, FACFAS

Dr. Jeff Baller, DPM, FACFAS

Dr. David Dowell DPM,ABPM

Patient Registration Form

Date:_____Patient Name:_____SSN:_____

Male:__Female:__Birth date:_____Home Phone_____Alternate Phone:_____

Address:_____City:_____State:_____Zip:_____

Minor:__Single:__Married:__Widowed:__Divorced:__Separated:__E-Mail Address_____

Employer:_____Work Phone:_____

If a student, name of school and address:_____

Emergency Contact:_____Phone:_____Cell:_____

Whom may we thank for referring you?_____Family Doctor:_____

Responsible Party

Name of person responsible for this account:_____Relationship to Patient:_____

SSN:_____Birth date:_____Home Phone:_____Cell:_____

Insurance Information

List the name of each of your insurance carriers:_____

_____

We will need a copy of your insurance cards before being seen by the physician.

Information and Assignment of Benefits

I authorize the release of any medical information necessary to process any of my claims. I permit a copy of this authorization to be used in place of the original.

Date:_____Signature:_____

I hereby authorize the physicians of this company to apply for benefits on my behalf for covered services rendered by them or by their order. I request that payment from my insurance company be made directly to the physician. I certify that the information I have reported with regard to my insurance coverage is correct. I permit a copy of this authorization to be used in place of the original. This authorization may be revoked by either me or my insurance company at any time.

Date:_____Signature:_____

Notice of Privacy Practices Acknowledgment

Copper Top Foot & Ankle Clinic / Copper Top Sports Medicine Clinic

225 Physician's Park Drive

Suite 102

Poplar Bluff, MO 63901

573-785-4546

I understand that under the Health Insurance Portability and Accountability Act (HIPAA), I have certain rights to privacy regarding my protected health information. I acknowledge that I have received or have been given the opportunity to receive a copy of your Notice of Privacy Practices. I also understand that this practice has the right to change its Notice of Privacy Practices and that I may contact the practice at any time to obtain a current copy of the Notice of Privacy Practices.

_____ _____

Patient Name or Legal Guardian (print) Date

_____

Signature

Office use only

We have made the following attempt to obtain the patient's signature acknowledging receipt of the Notice of Privacy Practices:

Date:_____Attempt:_____

Staff Name:_____

Confidential New Patient Questionnaire

Dr. Valandingham/Dr. Baller/Dr. Dowell

Copper Top foot & Ankle / Copper Top Sports Medicine Clinic

Name:_____Date:_____

Birth date:_____Age:_____Height:_____Weight:_____Shoe size:_____

What problems bring you to our office?_____

_____

What treatments and self help or over the counter products have you used to help these problems?_____

Who referred you to our office?_____

Have you been treated for this condition before?_____

Who is your Primary Care Physician?_____Date of last physical_____

Medical History

__Accident/Injuries__Anemia__Asthma__BleedingDisorders__Bronchitis__Cancer__Diabetes__Depressi onAnxiety__DVT__Epilepsy/Seizures__ Foot Problems__Gout__Heart Attack__Heart Disease__Kidney orBladderDisease__LiverDisease__RheumaticFever__StomachUlcer/Reflux__ThyroidDisease__Vascular/ Circulatory__Other:_____

Surgical History

Operation	Date	Hospital	Surgeon

(please place a check by appropriate family member) Family History

Father __Arthritis__Cancer__Diabetes__DVT__Heart Trouble__High Blood pressure__Kidney Disease __Mental/Emotional Disease__Reaction to Anesthesia__Stroke

Mother __Arthritis__Cancer__Diabetes__DVT__Heart Trouble__High Blood pressure__Kidney Disease __Mental/Emotional Disease__Reaction to Anesthesia__Stroke

Brother__Arthritis__Cancer__Diabetes__DVT__Heart Trouble__High Blood pressure__Kidney Disease __Mental/Emotional Disease__Reaction to Anesthesia__Stroke

Sister __Arthritis__Cancer__Diabetes__DVT__Heart Trouble__High Blood pressure__Kidney Disease __Mental/Emotional Disease__Reaction to Anesthesia__Stroke

Son __Arthritis__Cancer__Diabetes__DVT__Heart Trouble__High Blood pressure__Kidney Disease __Mental/Emotional Disease__Reaction to Anesthesia__Stroke

Daugh. __Arthritis__Cancer__Diabetes__DVT__Heart Trouble__High Blood pressure__Kidney Disease __Mental/Emotional Disease__Reaction to Anesthesia__Stroke

Please list all the medications you are currently taking (include birth control pills, insulin, aspirin, and all over the counter medicines):

Medication	Dose	How often

I am allergic to (include medicines, foods, pollens, latex, etc.), and what type of reaction you had:

_____

_____

Social History

Who do you live with? Parents Spouse Children Significant other Alone (circle one)

How many children do you have?_____

Are you currently Employed Unemployed Disabled (circle one)

Occupation (current or former):_____

Do you drink caffeinated beverages (cola, coffee, tea)? Yes if so how many per day___ No

Do you participate in regular exercise?_____

Are you a competitive athlete?_____

Do you now, or have you ever smoked?_____How much do you smoke per day_____How long_____

If you no longer smoke, when did you quit?_____

Do you now, or did you ever drink alcohol?_____How much?_____

Do you now, or have you ever used recreational drugs?_____

Which drugs and how much?_____

If you no longer use drugs, when did you quit?_____

Check all that apply

Constitutional Symptoms
__fever
__chills
__night sweats
__fatigue
__recent weight loss/gain

Cardiovascular
__cold feet
__irregular or fast heartbeat
__pain in calves
__swelling in feet/ankles/hands

Endocrine
__heat/cold intolerance
__excessive thirst or urination

Ear,Nose,Mouth,Throat
__difficulty swallowing
__ear infections/drainage
__hearing loss or ringing
__hoarseness
__loss of balance
__nasal stuffiness
__neck pain/stiffness
__nosebleeds
__sore throat/tonsils
__swollen glands in neck

Eyes
__blurred/double vision
__dry eyes
__wears glasses/contacts

Gastrointestinal
__abdominal pain
__bloating
__blood in stool
__change in bowel pattern
__constipation
__frequent diarrhea
__gas
__heartburn
__loss of appetite
__nausea/vomiting
__rectal bleeding

Genitourinary
__blood in urine
__burning or painful urination
__change in force/flow
__frequent urination

Skin
__acne
__dermatitis
__hives
__irregular moles
__rash/itching
__ulcers
__warts

Hematologic/Lymphatic
__slow to heal after cuts
__phlebitis/blood clots

Males
__difficulty urinating
__penile discharge
__testicle pain
__testicular/scrotal mass

Musculoskeletal/ Neuromuscular
__burning in feet/legs
__hip/knee/low back pain
__joint pain/stiffness
__muscle aches/cramps
__numbness feet/legs
__weakness of muscle/joints

Neurological
__convulsions/seizures
__frequent recurring headaches
__light headed/dizzy
__numbness or tingling

Psychiatric
__chemical dependency
__depression
__memory loss/confusion
__suicidal thoughts

Respiratory
__asthma or wheezing
__cough
__phlegm
__shortness of breath
__snoring at night
__spitting up blood

Females
__breast pain,mass or discharge
__heavy bleeding
__irregular period
__prolonged period
__severe menstrual pain
__vaginal discharge
__are you pregnant
Yes or No
Date of last period_____

Is there anything you wish to tell the physician privately? Yes No

I hereby give Dr. Vanlandingham / Dr. Baller/ Dr. Dowell permission to diagnose and administer treatment for my condition.

Patient Signature_____ Date_____

Physician Signature_____ Date_____