COLORADO CENTER FOR PODIATRIC SPORTS MEDICINE

JAMES D. YAKEL, D.P.M.

NAME ___________________________________DATE OF BIRTH __________AGE_____SEX: M F

ADDRESS ____

CITY ____________________________________ STATE _________ ZIP CODE________________

PHONE ____________________________ EMAIL _______________________________________

MARITAL STATUS: M S D W OTHER PRIMARY CARE PHYSICIAN________________________

HOW DID YOU HEAR ABOUT OUR OFFICE?____

PERSON RESPONSIBLE FOR ACCOUNT ____

PATIENT OR PARENT EMPLOYER INFORMATION

OCCUPATION ____________________________________

EMPLOYERS NAME________________________________PHONE_________________________

INSURANCE INFORMATION

PRIMARY INSURANCE ____

SUBSCRIBER NAME _________________________ ID# _______________ GROUP# ___________

SECONDARY INSURANCE ____

SUBSCRIBER NAME ________________________ ID# _______________ GROUP# ____________

I, the undersigned, consent to any and all such medical care which may include routine diagnostic procedures, x-rays, injections, medical treatment, and medications deemed necessary to diagnose or treat my foot/ankle problem. I agree that I am responsible for the payment of all charges incurred by me for any treatment and the cost of collection of unpaid balance. I authorize release of any medical information to process this claim or future claims and authorize my insurance benefits to be paid to Colorado Center for Podiatric Sports Medicine.

PRIVACY PRACTICES

I have received, read, and understand your *Notice of Privacy Practices.* I understand that this organization has the right to change its *Notice of Privacy Practices* and that I may contact this organization at any time to obtain a current copy of the *Notice of Private Practices.* I also understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or health care operations.

SIGNATURE ____ DATE ____________________

CURRENT FOOT/ANKLE PROBLEM (Please be as specific as possible)

____

____

PATIENT SHOE SIZE ___________________

PATIENT MEDICAL HISTORY (Please check all that apply)

___Heart Trouble ___Liver Disease ___Kidney Disease ___Gout

___High Blood Pressure ___Diabetes ___Arthritis ___Stroke/Heart Attack

___Asthma/Bronchitis ___Cancer ___Stomach Ulcers ___Depression/Anxiety

___ Circulation Problems ___Blood Thinners ___Epilepsy/Seizures ___Heart Valve

___ Joint Replacement ___Other, Specify ____

ALLERGIES (Please circle all that apply and add any not listed)

Penicillin Tapes/Adhesives Novocain Aspirin Codeine Food, Specify________________

Other, Specify ____

PREVIOUS SURGERIES & HOSPITALIZATIONS

1. ____4. _____________________________________

2. ____5. _____________________________________

3. ____6.______________________________________

MEDICATIONS

1. ____5. _____________________________________

2. ____6. _____________________________________

3. ____7.______________________________________

4. ____8. _____________________________________

Preferred Pharmacy ____

Do you use tobacco? _____Yes ____Never ____Former

If yes, how much? ____

If former, when did you stop? ______________________________

Did you receive a flu vaccine? _____Yes _____No When? _____________________________

If over 65, have you received a pneumococcal vaccine? ____Yes ____No When? ________

PLEASE CIRCLE ANY CURRENT OR PREVIOUS PROBLEMS

HEART: Chest Pain Pounding Murmur Rheumatic Fever Skipped Beats
Artificial Valve Other ____

BLOOD VESSELS: Leg Cramps Swelling Cold Feet Poor Circulation Other _______________

LUNGS: Wheeze Cough Short of Breath Coughing up Blood Other _________________

ABDOMEN: Nausea Vomiting Vomiting Blood Diarrhea Constipation Pain
Heartburn Hepatitis Pancreatitis Hemorrhoids Blood in Stool
Weight Change Appetite Change Change in Bowel Habits Other _________

URINARY TRACT: Stones Infections Frequency Burning Decreased Forced
Difficulty Controlling Bladder Other____________________________________

NERVOUS SYSTEM: Headaches Dizziness Seizures or Epilepsy Fainting Alcoholism
Addictions Falls Poor Balance IV Drug Use Other______________________

MUSCLES BONES JOINTS: Fractures Pain Weakness Fatigue Joint Replacement Artificial Joint
Difficulty Walking Joint Pain & Swelling Low Back Pain Sciatica Other_____

BLOOD: Easy Bruising Prolonged Bleeding Surgical Hemorrhage Excessive Bleeding
Anemia Transfers Blood Clots Phlebitis Other________________________

SKIN: Rashes Lumps/Bumps Changing Moles Psoriasis Finger Nail Problems
Itching Dry Skin Other____

Other Problems?

____

________________________________ ___________________________________
Patient Signature Date Physician Signature Date