Dr Tyler V Jolley, DPM
435-462-FOOT(3668)
www.eliteankleandfoot.com

New Patient Form

Patient Last name: _____ First name_____ Age_____DOB _____/_____/_____
Address:_____ Apt_____ City_____ State_____ Zip_____
Home Phone#_____ Cell Phone#_____ Work Phone # _____
(Circle which phone number you prefer to use for reminder calls)
Sex M F Social Security # _____-____-_____ Email_____
Occupation: _____ Work Phone#_____
Marital Status: _____ Spouse/Partner's name_____
Emergency Contact_____ Phone#_____ Relationship to patient_____
If patient is a Minor: Responsible Party's Name_____ Relationship to Minor_____

How did you hear about us? _____
Primary Care Physician_____ Phone #_____
Insurance:
_____ID#_____Group/Policy#_____
Name of Policy Holder_____ SS#_____-_____-_____ Relationship to patient_____
Is referral required? Yes No (patient responsible to obtain referrals)
Secondary Insurance_____ID#_____Groupe/Policy#_____
Name of Policy Holder_____ SS#_____-_____-_____ Relationship to patient_____

Allergies/Sensitivities:_____**Describe Reaction:**_____
_____**Describe Reaction:**_____

Current medications/supplements (Prescription and Over-the-counter):
Medication:_____Dose:_____Frequency:_____
Medication:_____Dose:_____Frequency:_____
Medication:_____Dose:_____Frequency:_____
Medication:_____Dose:_____Frequency:_____
Medication:_____Dose:_____Frequency:_____

Medical History – Please indicate if you, personally, have experienced any of the following:

Cardiovascular
_____High Blood Pressure
_____Chest Pain
_____Palpitation/Arrhythmia
_____Heart Attack
_____Congestive Heart Failure
_____Stroke/TIA
_____Coronary Artery Disease:
_____High Cholesterol

Liver
_____Hepatitis/Cirrhosis

Hematologic
_____Bleeding Disorders
_____Clotting Disorders
_____History of DVT/Blood Clots

Musculoskeletal
_____Fibromyalgia
_____Back/Neck Pain
_____Osteoporosis/Osteopenia
_____Osteoarthritis
_____Gout

Respiratory
___Shortness of Breath
___COPD
___Asthma
___Emphysema

Genitourinary
___Recurrent Urinary Tract Infections
__Prostate Enlargement
___Prostate Cancer

Endocrine/Rheumatology
___Diabetes (insulin dependent)
___Diabetes (non-insulin dependent)
___Thyroid Disease
___Adrenal Disease
___Rheumatoid arthritis
___Seronegative arthropathy

Dermatology
___Melanoma
___Squamous Cell Carcinoma
___Basal Cell Carcinoma
__Cysts

Gastrointestinal
___Reflux/Heartburn
___Crohn's Disease
___Ulcerative Colitis
___Irritable Bowel Syndrome
___Bleeding Ulcers

Kidney
___Kidney Disease
___Kidney Failure
___Kidney Infection
___Kidney Stone

Infectious Disease
___HIV
___Chronic Skin Infection
___MRSA

Nervous/Psychiatric
___Seizure Disorder
___Multiple Sclerosis
___Parkinson's Disease
___Depression/Anxiety
___Peripheral Neuropathy

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Surgical History – Please list ALL surgeries you have had:

Surgery: Year: Surgeon: Complications:

_____

_____

_____

_____

Are you pregnant? ___Yes ___No Are you nursing? ___Yes ___No

When did you have your last tetanus shot? _____

Social History: Alcohol use: ___ Never ___No longer use ___ Current user -- # of drinks per day/week/month_____

Tobacco use: ___ Never ___No longer use ___Current user -- # of cigarettes per day/week/month _____

Recreational drugs: ___Never ___ No longer use ___Current user – Name of drug & frequency _____

Family History: Please indicate any known health conditions in your family (draw a line from the person to their condition)

Alcoholism Anemia Anxiety Arthritis Cancer Cataracts Diabetes Hypertension Kidney Disease Stroke

Mother Father Brother Sister Maternal Grandfather Maternal Grandmother Paternal Grandfather Paternal Grandmother

Medical Information Release

I acknowledge that I have been provided a copy of the NOTICE OF PRIVACY PRACTICES of **Elite Ankle and Foot** ("EAF") and that EAF may release all or portions of my medical record to me, and to people or companies responsible to pay the charges for my care, such as my insurance or health benefits companies, or worker's compensation carriers. I further acknowledge that EAF may disclose my patient information to referring or treating health care providers, and for payment and health care operations. I hereby authorize EAF to obtain my medical information from other health care entities and providers, including but not limited to, copies of lab results, diagnostic test reports, film/images, and other clinic information deemed necessary by EAF physicians or representatives. I understand that I may inspect my protected health information, request more information, and revoke this authorization, as permitted by the federal privacy regulations and in accordance with EAF's privacy policy.

Consent for Treatment

I hereby consent to the medical treatment, diagnostic, and laboratory tests, and other procedures, which the physician(s) may deem advisable in treatment of my case (or as legal guardian for patient). EAF will determine the proper disposition of any tissues, parts, or body fluids consistent with state and federal laws. This agreement will remain in effect until I choose to revoke it in writing.

Financial Responsibility and Agreement

I hereby authorize any benefits due me to be paid directly to Elite Ankle and Foot. I understand and agree that I am financially responsible for all deductible amounts, co-insurance, co-pay or non-covered services or services deemed as "non-medically necessary" by my third party insurance carrier which could include orthotics, braces, splints, over the counter medications, heel cups, pads, toe separators, etc.. I agree that I am responsible for satisfying any conditions necessary for insurance or health benefits, including obtaining a valid referral from my primary care physician if necessary. In consideration for medical services rendered, I (we) acknowledge that I (we) have received notice of EAF's financial policy and agree to pay for said medical services according to such terms.

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 changes in my medical status.

Patient/Responsible Party Signature:_____ Date:_____

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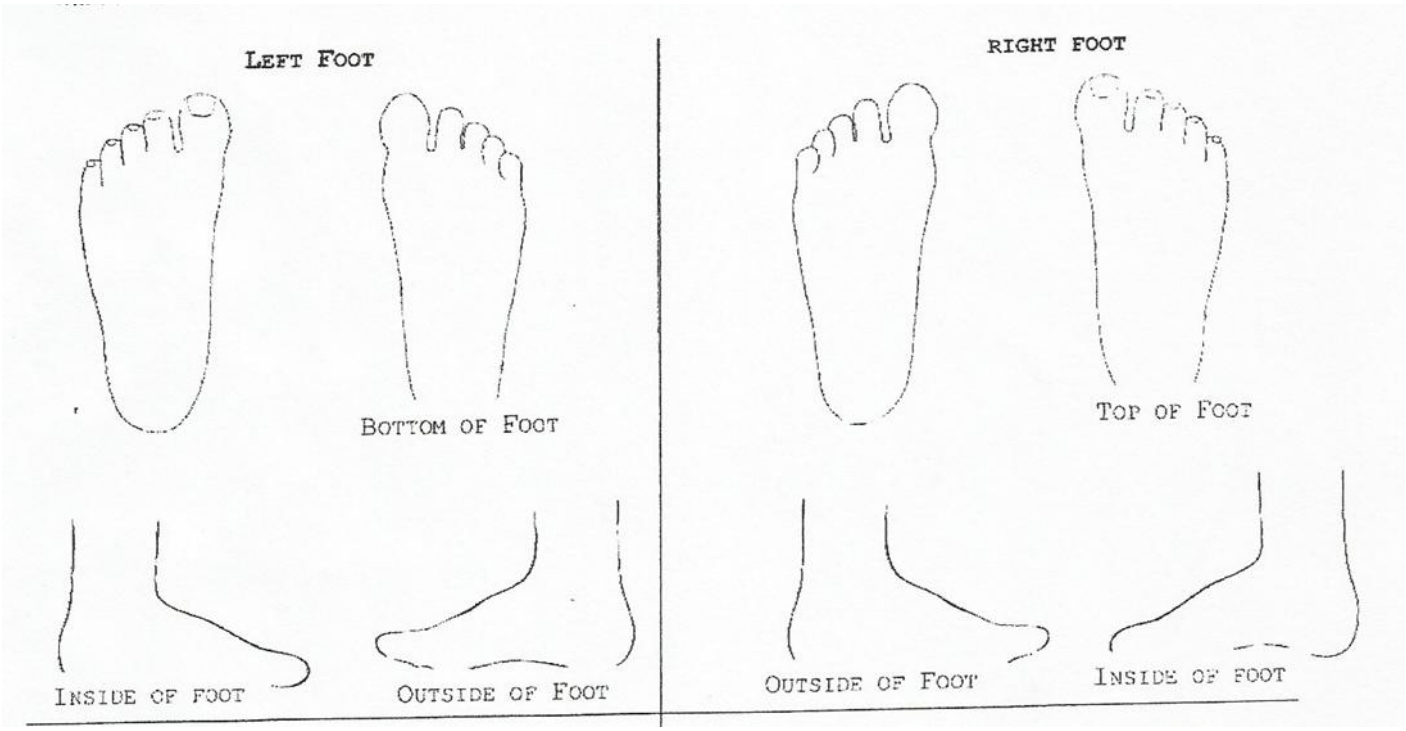
Patient Name_____

Please mark on the picture below where the pain or problem is located:



Problem(s):_____

Was this problem caused by an injury? ☐No ☐Yes If yes, was it a work related injury? ☐No ☐Yes

How long ago did this problem start? _____Days _____Weeks _____Months _____Years

Did your pain or problem: _____Begin all of a sudden _____Gradually developed over time

How would you describe your pain? ☐Sharp ☐Dull ☐Aching ☐Burning ☐Radiating

☐Itching ☐Stabbing ☐Other_____

How would you rate your pain on a scale from 1 to 10? (please circle)

(no pain) 0 1 2 3 4 5 6 7 8 9 10 (worst)

What makes your pain or problem feel worse? ☐ Walking ☐ Standing ☐ Daily Activities

☐ Resting ☐ Running ☐ Dress Shoes ☐ High Heels ☐ Any Closed Toe Shoe

☐ Worse At Night ☐ Other _____

What makes your pain or problem feel better? _____