## *Welcome to Gig Harbor Foot and Ankle Clinic*

Patient Name_____ Middle initial___

Mailing Address_____

City & State_____ Zip Code_____

Home Phone_____ Cellphone_____

E-mail_____

Sex: M F Date of Birth ___/___/_____ Marital Status: S M D W

Name of referring physician _____

Primary care physician _____

Specialty physician _____ Primary Reason_____

**Emergency Contact:**

Name _____ Relationship_____

Phone number _____

**Insurance Information:**

Name of Insurance _____

ID Number _____

Secondary Insurance _____

ID Number _____

I hereby give my permission for the doctor to render the proposed podiatric examination and treatment. I understand that I am financially responsible to the physician for all charges incurred by my dependants or me. I authorize the release of any medical information necessary to process any claim and request payment of insurance benefits due to be paid to the physician supplying the service.

Signature _____ Date _____

Circle one: Self Parent POA

**Gig Harbor Foot and Ankle Clinic**
DR JAMES D. MCALEXANDER, DPM
3309 56TH ST NW, SUITE 108 GIG HARBOR, WA 98335
PHONE: 253-858-8100 FAX: 253-858-6017 EMAIL: ghfoot.ankle@gmail.com

# Medical Information Release Form
# HIPPA Release Form

_____ _____
Patient Name (Please Print) Date of Birth

I authorize the release of information including the diagnosis, records, examination rendered to me and claims form information. This information may be released to :

_____ _____
Name (Please Print) Relationship

_____
Initial here if you do **not** want your information released to anyone.

The Release of Information will remain in effect until terminated by the patient in writing.

## Messages

Please Call: Home ___ Work___ Cell___ Phone number _____

If unable to reach me: ___ Leave a detailed message
___ Leave a message asking me to return your call

Patient Signature_____ Date _____

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## Acknowledgment of Receipt of Notice of Privacy Practices

I acknowledge that I am aware of the Notice of Privacy Practices and that I have read or had the opportunity to read it if I so choose and that I understand the notice.

_____ _____
Patient Signature or Name of Authorized Representative Date

_____
Print Name

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## Notice of Financial Responsibility

I understand that I am financially responsible to the physician for all charges incurred by me or my dependents that may not be a covered benefit according to my insurance plan. I hereby authorize Dr. McAlexander to make a podiatric examination to determine appropriate treatment. I understand that if I do not call to cancel within 24 hours or do not show up to my appointment, I will be charged with a $20 fee.

I authorize the release of any medical information necessary to process an insurance claim and request that payment of insurance benefits be made directly to Dr. McAlexander.

_____ _____
Patient Signature or Name of Authorized Representative Date

_____
Print Name

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**Foot Health Information:**

What is your foot/ankle concern?_____
When did it begin?_____ Was it due to an injury/accident? Yes No
If so, describe what happened:_____
What aggravates it? _____
Is it improving or worsening?_____
How have you treated it so far?_____
On a scale of 1-10 (10 being the worst), rate your pain level _____
Describe your pain (burning, throbbing, stabbing, ect)_____
Height _____ Weight _____ Shoe type _____

**Are you allergic or do you have any reaction (sensitivity) to medications, tape, and/or chemicals?**

Medication Reaction

_____
_____
_____
_____
_____

**Please list all surgeries you have had:**

_____
_____
_____
_____
_____

**Please list medications you are taking:**

_____
_____
_____
_____
_____

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**Habits and Social History:**

**Do you or have you ever smoked tobacco? (circle one)**

Never Former Current everyday Current somedays

**Do you or have you ever used any forms of tobacco or nicotine**

No Yes

**What is your level of alcohol consumption? (circle one)**

None Occasional Moderate Heavy

**Do you use any illicit or recreational drugs? (circle one)**

No Yes

**What is your level of caffeine consumption? (circle one)**

None Occasional Moderate Heavy

| **Family History:** | **Yes** | **No** | **Family member** | **Deceased** |
|---|---|---|---|---|
| Cancer | ___ | ___ | _____ | _____ |
| Diabetes | ___ | ___ | _____ | _____ |
| High Blood Pressure | ___ | ___ | _____ | _____ |
| Heart Disease | ___ | ___ | _____ | _____ |
| Kidney Disease | ___ | ___ | _____ | _____ |
| Kidney Stones | ___ | ___ | _____ | _____ |

Other: _____

## Have you had any of the following medical conditions or occurrences? Check all that apply:

**Cardiovascular (heart & blood vessels)**

___ Heart attack
___ Chest pains
___ Abnormal Heart rhythm/arrhythmia
___ High blood pressure
___ Elevated cholesterol
___ Aneurysm
___ Phlebitis (blood clots)
___ Swelling of ankles/legs
___ Shortness of breath with activity
___ Shortness of breath while lying flat

**Pulmonary (lungs)**

___ Pneumonia
___ Asthma
___ Emphysema
___ Chronic bronchitis
___ Wheezing
___ Shortness of breath
___ Chronic cough

**Psychiatric**

___ Depression
___ Anxiety disorder
___ Eating disorder

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**Gastrointestinal (intestines)**
___ Hepatitis: type A, B, C, or D?
___ Cirrhosis
___ Yellow jaundice
___ Stomach ulcers
___ Reflux
___ Colitis or enteritis
___ Diverticulitis
___ Nausea or vomiting
___ Pain in abdomen
___ Gallbladder disease or stones
___ Pancreatitis
___ Blood in stool
___ Constipation

**Endocrine (hormones)**
___ Hypothyroid (low thyroid)
___ Hyperthyroid (high thyroid)
___ Diabetes
Diagnosed by?_____ Date_____
___ Calcium disorder
___ Adrenal disorder
___ Heat or cold sensitivity
___ Frequent urination

**Blood & Lymphatic**
___ Anemic
___ Raynaud's syndrome
___ Bleeding disorder
___ Polycythemia
___ Sickle cell disease
___ Lymphoma/leukemia/multiple myeloma (circle one of the above)
___ Easy bruising
___ Enlarged lymph glands

**Neurologic**
___ Stroke-Weakness on R or L? ___
___ Spinal cord injury-Area affected_____
___ Seizures-type_____
___ Migraine or frequent headaches
___ Vertigo (dizzy spells)
___ Loss of consciousness
___ Confusion or memory loss
___ Neuropathy
Diagnosed by?_____ Date _____

**Renal (kidneys)**
___ Kidney failure
___ Dialysis
___ Cysts

**Musculoskeletal**
___ Back injury
___ Herniated disc
___ Arthritis
___ Bone disease
___ Joint pain
___ Stiffness
___ Fractures (broken bones)
___ Osteoporosis
___ Muscle disease
___ Gout
___ Rheumatoid arthritis

**Skin**
___ Lumps or bumps-Where_____
___ Rashes- type & where_____
___ Open sores-Where_____
How long?_____
___ Psoriasis

**Head & Eyes**
___ Sinus infections/problems
___ Hay fever
___ Nose bleeds
___ Glaucoma
___ Macular degeneration
___ Vision problems
___ Deafness
___ Ear infections

**Infections & Immune Related Issues**
___ AIDS
___ Chronic fatigue syndrome
___ Fibromyalgia
___ Itching
___ Hives

**General**
___ Weight gain/loss
___ Sweating at night
___ Decreased strength/vitality
___ Cancer-Where_____
___ Fever or chills

*Thank you*