FOOT & ANKLE SPECIALISTS *of Ohio*

Dr. Gladys G. dė León — Dr. Stephen J. Frania

Podiatric & Sports Medicine • Reconstructive Foot & Ankle Surgery

www.fasohio.com

WELCOME TO OUR OFFICE

Patient's Name: ______________________________ Date: ____________________

Address: ____________________________________ SSN: ____________________

City: ____________________ State: ______________ Zip Code: ________________

Sex: M _____ F _____ Date of Birth: ______________ Age: _____ Marital Status: S/M/W/Other

Home Phone #: ________________________ Work Phone #: ______________________

Cell Phone #: ________________________

Place of Employment: ______________________ Job Title: ______________________

Work Type: Sitting / Semi-Active / Active Any Shoe Wear Restrictions: ________________

Who may we thank for referring you to our office? Doctor ______________________

Friend ______________________________ Yellow Pages _____ Newspaper Ad _______

Insurance Directory _____ Other: ____

Insurance Information

Insurance #1: ______________________ Subscriber: ___________________________

Policy #: ____________________ Group #: ______________ DOB (insured): _________

Insurance #2: ______________________ Subscriber: ___________________________

Policy #: ____________________ Group #: ______________ DOB (insured): _________

Emergency Contact/Guardian if patient is a minor: __________________ Phone #: __________

Spouse's Name: ____________________ Spouse's Employer: ________________________

MENTOR — 7062 Wayside Dr. • Mentor, OH 44060 • (440) 357-8418 • Fax: (440) 357-8427

WILLOUGHBY — 36060 Euclid Ave., Suite 107 • Willoughby, OH 44094 • (440) 975-8823 • Fax: (440) 975-5763

CONCORD — 7590 Auburn Rd., Suite 214 • Concord, OH 44060 • (440) 357-8418 • Fax: (440) 357-8427

Patient Name: ______________________________ DOB: _______________ Age: ____________

AUTHORIZATIONS

*****YOU MUST COMPLETE THIS SECTION*****

Yes No I hereby authorize benefits directly to the physician of the surgical and/or medical benefits.

Yes No I understand I am responsible for any portion of my bill not covered by my insurance co.

Yes No I hereby authorize release of information and/or medical records of myself to any treating physician or insurance company.

Yes No The information authorized for release may include information which may be considered a communicable or venereal disease, including hepatitis, syphilis, gonorrhea, HIV or AIDS.

Yes No I voluntarily request the doctors and medical staff of Foot & Ankle Specialists of Ohio to treat my condition as they deem necessary.

Yes I understand I may be subjèct to a $25 fee for appointment not cancelled 24 hours in advance.

Yes I have been informed of, & reviewed a copy of this office's HIPPA policy.

I understand all of the above & hereby state that the information is correct to the best of my knowledge.

________________________________ __________ ________________________________

Signature of Responsible Party Date Signature of Patient

Medical Information

Height: _______ Weight: _______ Shoe Size: _______ Previous Podiatrist: ____________________

Family Physician: ______________________________ Date of Last Physical: ________________

What is your foot/ankle problem? ____

____

____

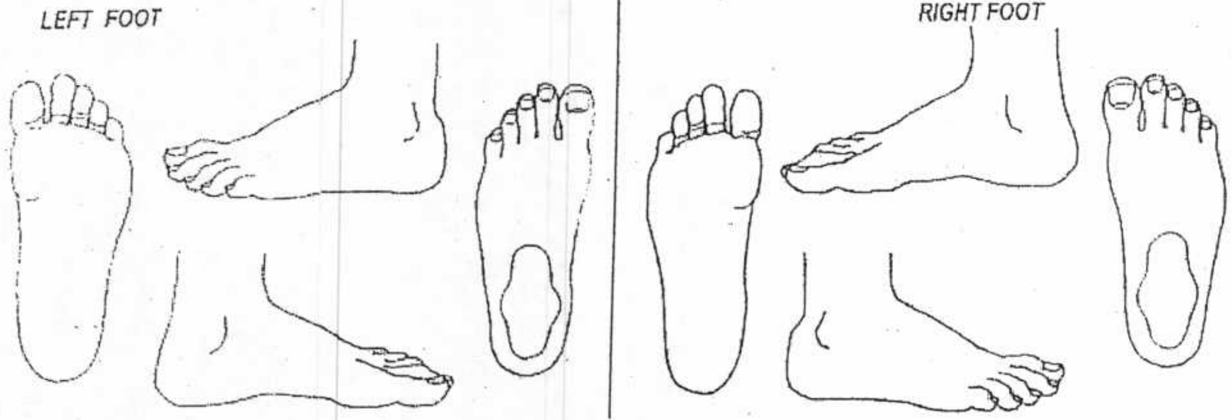
How long has this been a problem? ____

Have you had any treatment for this problem? ____________________________________

____

Patient Name: ______________________ DOB: __________ Age: __________

Please indicate where your problem is located:



Personal & Family Medical History

List personal & family medical conditions, use space below to add additional conditions:

CONDITION:	YOU:	FATHER:	MOTHER:	SIBLING:	CHILDREN:	ADDITIONAL INFO:
ARTHRITIS						
DIABETES						
FOOT PROBLEMS						
BLOOD CLOTS/DVT						
CIRCULATION PROBLEMS						
HEART DISEASE						
DECEASED (indicate age)						

Please list other medical problems: ______________________

____

Surgeries & Hospitalizations

List ALL previous surgeries & hospitalizations, dates & reasons:

APPROXIMATE DATE	PREVIOUS SURGERIES/HOSPITALIZATIONS	REASON

Patient Name: ______________________ DOB: __________ Age__________

Medications

Please list ALL medications (with dosages). Include non-prescription, herbs & supplements:

NAME OF MEDICATION	REASON FOR TAKING	DOSAGE	HOW OFTEN DO YOU TAKE IT?

Allergies

MEDICATION/FOOD	REACTION

Social History

	NEVER	OCCASSIONAL	FREQUENCY
HERBAL SUPPLEMENTS			
ALCOHOL			
TOBACCO (PACKS/DAY & YEARS)			

Review of Systems

(Doctor will ask)

General Cardio Respiratory Ortho Other