

| | | |
|---|--|-----------------------------|
| Name: _____ | Chart #: _____ | Date of birth: _____ |
| Ethnicity: <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino | <input type="checkbox"/> Declined to specify | |
| Race: <input type="checkbox"/> Asian <input type="checkbox"/> American Indian or Alaska Native | <input type="checkbox"/> Black or African American | |
| <input type="checkbox"/> White <input type="checkbox"/> Native Hawaiian or other Pacific Islander | <input type="checkbox"/> Declined to specify | |
| Preferred Language: _____ | <input type="checkbox"/> Declined to specify | |
| Pharmacy Name: _____ | Pharmacy Phone: _____ | |
| Pharmacy Address: _____ | City, State, Zip: _____ | |
| Primary Care Physician: _____ | Phone: _____ | Date Last Seen: _____ |
| Address: _____ | | |
| Referring Physician: _____ | Phone: _____ | Date Last Seen: _____ |
| Address: _____ | | |

Privacy Information Preferences

Do you want to be exempt from public reporting? ☐ Yes ☐ No Can we send mail to the address on file? ☐ Yes ☐ No

Can we call the phone number on file? ☐ Yes ☐ No Can we leave voicemail on machine? ☐ Yes ☐ No

Will you allow us to send internet based (e-mail) delivery of reminders and newsletters? ☐ Yes ☐ No

If yes, please provide your e-mail address: _____

Who can we leave messages with? ☐ Wife ☐ Husband ☐ Daughter ☐ Son ☐ Other:

Name(s): _____

Smoking Status

☐ Current Every Day ☐ Smoker, Current Status Unknown

☐ Current Some Day ☐ Heavy Tobacco ☐ Unknown If Ever

☐ Former ☐ Never ☐ Light Tobacco ☐ I decline to answer

Vital Signs

Blood Pressure: _____ / _____

Height: _____ Weight: _____

Current Medications

☐ No Known Medications ☐ I take the following medications:

Name: _____

Name: _____

Name: _____

Name: _____

Name: _____

Name: _____

Name: _____

Use the back of this form if more room is needed

Allergies

☐ No Known Allergies ☐ No Known Drug Allergies

Name: _____ Reaction: _____

Name: _____ Reaction: _____

Name: _____ Reaction: _____

Name: _____ Reaction: _____

Name: _____ Reaction: _____

Name: _____ Reaction: _____

Name: _____ Reaction: _____

Use the back of this form if more room is needed

Last Flu Shot Date: _____ **Did you get a pneumococcal vaccination?** ☐ Yes ☐ No

Have you fallen in the last 12 months? ☐ Yes ☐ No **Were you injured from the fall?** ☐ Yes ☐ No

Have you completed any Advanced Directives? ☐ Yes ☐ No

PLEASE READ AND SIGN: The information on my intake form(s) is correct to the best of my knowledge. I understand that throughout my treatment, I am responsible for notifying the physician and/or medical staff of any and all updates to the information listed above. (Assignment of Benefits): I authorize payment of medical benefits to the practice named above. (Release of Information): I authorize the release of any medical information necessary to process this claim. (HIPAA Privacy): I acknowledge that I received my HIPAA Privacy Practices Notice. (Medication History): I authorize the Doctor's office to retrieve my medication history.

Patient Signature: _____

Date: _____

History and Physical

Name: _____ DOB: _____ Chart Number: _____

Medical History:

| | | | | | |
|---|--|--|---|--|---|
| <input type="checkbox"/> Liver | <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Blood disorders | <input type="checkbox"/> Circulation problems | <input type="checkbox"/> Musculoskeletal | <input type="checkbox"/> Breathing issues |
| <input type="checkbox"/> Heart murmur | <input type="checkbox"/> Sleep apnea | <input type="checkbox"/> Gout | <input type="checkbox"/> Allergies | <input type="checkbox"/> Heart disease | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Blood clot | <input type="checkbox"/> Stomach/bowel | <input type="checkbox"/> Depression | <input type="checkbox"/> Anxiety disorder | <input type="checkbox"/> Mental illness | <input type="checkbox"/> Kidney disease |
| <input type="checkbox"/> Neuropathy (specify) _____ | <input type="checkbox"/> High cholesterol | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Cancer | <input type="checkbox"/> Hepatitis | |
| <input type="checkbox"/> Arthritis (specify) _____ | <input type="checkbox"/> Thyroid disease (specify) _____ | <input type="checkbox"/> Diabetes (type 1, type 2) | <input type="checkbox"/> HIV | <input type="checkbox"/> CVA | |
| Are you pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No | Are you nursing? <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Skin disorders | <input type="checkbox"/> Stroke | | |

Surgical History ☐ None ☐ Appendectomy ☐ C-Section ☐ Angioplasty ☐ Bypass ☐ Cataracts ☐ Cholecystectomy

Have you ever had any surgical procedures on foot/ankle or anywhere else on your body? ☐ Yes ☐ No

If yes, please describe: _____

Do you have any artificial joints? ☐ Yes (where? _____) ☐ No Do you have an artificial heart valve? ☐ Yes ☐ No

Social History

Do you smoke? ☐ Yes ☐ No If yes how many packs per day? ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 For how long? _____

Do you drink alcohol? ☐ Yes, everyday (5-7 days/week) ☐ Yes, occasionally/socially ☐ No/Rarely

Substance abuse: ☐ Yes, I have a current substance abuse problem. Please specify: _____

☐ Yes, I had a past substance abuse problem. Please specify: _____

☐ No, I have never had a substance abuse problem

What is your occupation? _____ Does it involve mostly ☐ standing or ☐ sitting

Do you exercise regularly? ☐ No, I do not exercise regularly ☐ Yes, I do the following regular exercise: _____

Family History

Is there any family history (blood relative) of: (Please indicate family member)

| | | | |
|---|-------|--|-------|
| <input type="checkbox"/> Alzheimer's | _____ | <input type="checkbox"/> Depression | _____ |
| <input type="checkbox"/> Arthritis | _____ | <input type="checkbox"/> Diabetes | _____ |
| <input type="checkbox"/> Bleeding disorders | _____ | <input type="checkbox"/> Emphysema | _____ |
| <input type="checkbox"/> Blood clot | _____ | <input type="checkbox"/> Heart disease | _____ |
| <input type="checkbox"/> Cancer | _____ | <input type="checkbox"/> High Blood Pressure | _____ |
| <input type="checkbox"/> Cataracts | _____ | <input type="checkbox"/> Neurological | _____ |
| <input type="checkbox"/> Circulation problems | _____ | <input type="checkbox"/> Strokes | _____ |
| <input type="checkbox"/> Other (specify): | _____ | | |

Review of Systems

(Please check the box if you currently have any of these symptoms or check "NONE")

| | | | | | |
|-------------------------|--|--|--|--|---|
| Cardiovascular | <input type="checkbox"/> leg pain when walking | <input type="checkbox"/> fever | <input type="checkbox"/> chest pain/pressure | <input type="checkbox"/> leg swelling | <input type="checkbox"/> cold hands/feet |
| | <input type="checkbox"/> fainting | <input type="checkbox"/> palpitations | <input type="checkbox"/> vascular disease | <input type="checkbox"/> valve problems | <input type="checkbox"/> NONE |
| Genitourinary | <input type="checkbox"/> blood in urine | <input type="checkbox"/> hesitancy | <input type="checkbox"/> incontinence | <input type="checkbox"/> increased urgency | |
| | <input type="checkbox"/> decreased frequency | <input type="checkbox"/> excessive urination | <input type="checkbox"/> kidney disease | <input type="checkbox"/> kidney stones | <input type="checkbox"/> NONE |
| Gastrointestinal | <input type="checkbox"/> abdominal pain | <input type="checkbox"/> heartburn | <input type="checkbox"/> blood in stool | <input type="checkbox"/> vomiting | <input type="checkbox"/> constipation |
| | <input type="checkbox"/> diarrhea | <input type="checkbox"/> trouble swallowing | <input type="checkbox"/> decrease appetite | <input type="checkbox"/> increase appetite | <input type="checkbox"/> NONE |
| Integumentary | <input type="checkbox"/> athlete's foot | <input type="checkbox"/> nail abnormalities | <input type="checkbox"/> keloids | <input type="checkbox"/> itchiness | <input type="checkbox"/> dry, scaly skin |
| | | | | | <input type="checkbox"/> NONE |
| Hematologic | <input type="checkbox"/> lower leg ulcers | <input type="checkbox"/> sickle cell disease | <input type="checkbox"/> anemia | <input type="checkbox"/> blood thinners | <input type="checkbox"/> clotting disorders |
| | | | | | <input type="checkbox"/> NONE |
| Neurological | <input type="checkbox"/> tingling | <input type="checkbox"/> weakness | <input type="checkbox"/> seizures | <input type="checkbox"/> numbness | <input type="checkbox"/> headaches |
| | <input type="checkbox"/> tremors | <input type="checkbox"/> paralysis | | | <input type="checkbox"/> NONE |
| Musculoskeletal | <input type="checkbox"/> back pain | <input type="checkbox"/> joint swelling | <input type="checkbox"/> muscle weakness | <input type="checkbox"/> muscle pain | <input type="checkbox"/> neck pain |
| | <input type="checkbox"/> sciatica | <input type="checkbox"/> joint stiffness | <input type="checkbox"/> joint pain | <input type="checkbox"/> joint instability | <input type="checkbox"/> arthritis |
| | | | | | <input type="checkbox"/> NONE |
| Respiratory | <input type="checkbox"/> chest pain | <input type="checkbox"/> wheezing | <input type="checkbox"/> COPD | <input type="checkbox"/> coughing | <input type="checkbox"/> snoring |
| | <input type="checkbox"/> shortness of breath | <input type="checkbox"/> emphysema | | | <input type="checkbox"/> NONE |

PLEASE READ AND SIGN

The above information is correct to the best of my knowledge. I understand that throughout my treatment, I am responsible for notifying the physician and/or medical staff of any and all updates to the information listed above.

Patient Signature: _____

Date: _____

Name: _____ DOB: _____ Chart Number: _____

Sex: ☐ M ☐ F Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced SS#: _____

E-mail: _____ Spouse/Partner Name: _____

E-mail newsletters, reminders, statements, etc.

Emergency Name: _____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

Home #: _____ Cell #: _____ Other #: _____

Employer: _____ Phone: _____

Employer Address: _____ City: _____ State: _____ Zip: _____

Primary Insurance: _____ Are you the insured? ☐ Yes ☐ No**Insured Information**Subscriber Name: _____ Relationship to insured: ☐ Spouse ☐ Child ☐ Self ☐ otherPhone #: _____ Sex: ☐ Male ☐ Female DOB: ____/____/____

Address: _____

Policy ID: _____ Group ID: _____ Employer: _____

Secondary Insurance: _____ Are you the insured? ☐ Yes ☐ No**Insured Information**Subscriber Name: _____ Relationship to insured: ☐ Spouse ☐ Child ☐ Self ☐ OtherPhone #: _____ Sex: ☐ Male ☐ Female DOB: ____/____/____

Address: _____

Policy ID: _____ Group ID: _____ Employer: _____

How did you find out about our practice? ☐ Physician ☐ Internet ☐ Telephone book ☐ Family member ☐ Friend☐ Other: _____

What is the reason for your visit today? _____

Result of accident or work injury? ☐ Yes ☐ NoHow long has this bothered you? ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ days ☐ weeks ☐ months ☐ years

What treatments have you tried & have they been effective? _____

On a scale of 1-10 (1 being no pain and 10 being the worst) what is your level of pain? ____/10

The pain quality is: ☐ burning ☐ constant ☐ dull ☐ sharp ☐ shooting ☐ throbbing ☐ tingling Other: _____**PLEASE READ AND SIGN**

The above information is correct to the best of my knowledge. I understand that throughout my treatment, I am responsible for notifying the physician and/or medical staff of any and all updates to the information listed above.

Patient Signature: _____

Date: _____

MEDICARE AUTHORIZATION

I request that payment of authorized Medicare benefits be made to me or on my behalf to

Dr. Ian C. Klein for any services furnished me by that physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health

insurance" is indicated in item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assignment cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

X

Beneficiary Signature

Date

Insurance Authorization And Assignment Form

All professional services rendered are charged to the patient. The necessary forms will be completed to help expedite insurance carrier payments. However, the patient is responsible for all fees regardless of any insurance coverage. It is also customary to pay for services when rendered unless other arrangements have been made in advance with our office.

If hospitalization is indicated, the patient is responsible for furnishing insurance claim forms to the office prior to hospitalization.

I hereby authorize Dr. Ian Klein to furnish my information to insurance carriers concerning my illness and treatments and I hereby assign all payments for medical services rendered to myself or my dependents. I understand that I am responsible for any amount not covered by my insurance.

Insured/Date

Patient/Date