Name _____ Date of Birth _____

Patient Intake Form

Please fill out this form to the best of your knowledge. Your answers help us plan and provide your care.

Personal Information

Address: _____

Zip Code: _____ City: _____ State: _____ Age: _____ Sex: M F

Email: _____

Primary Language: _____**Race**: _____**Occupation**_____

Home Number:_____ **Mobile Number:**_____

Marital Status _____ Referring Physician: _____

PCP: _____ Last Seen Date: _____

Pharmacy Information

Pharmacy Name: _____ Address: _____

Zip Code: _____ City: _____ Phone: _____

Reason we are seeing you today:

_____

Medical Insurance Info: _____ ID: _____
Secondary Ins: _____ ID: _____
If Workers Comp Insurance please provide us with your Adjustors Information, Claims #, and Date of Accident:

_____
_____
_____.

Current Prescriptions *(list all medications you are taking at present)*

Medication name Dosage/ Route	How often
Example: Lasix 20 mg, PO	*Daily*

Any medication allergies? _____

Name _____ Date of Birth _____

Mental Health

Over the last 2 weeks, how many bad days have you had:	
Had little interest or pleasure in doing things?	
Felt down, depressed or hopeless?	

Past Medical History (*check all that apply)*

- Anemia
- Arthritis
- Asthma
- Blood clot *(DVT/PE)*
- Coronary artery disease (*Heart attack)*
- COPD/emphysema
- Cancer/History of cancer
- Chronic kidney disease
- Chronic liver disease/cirrhosis
- Congestive heart failure

above:

- Depression
- Diabetes Type I/II
- GERD
- Hepatitis (type ____)
- Hypertension *(High blood pressure)*
- Hyperlipidemia (*High cholesterol)*
- Migraine
- Seizure
- Stroke
- Thyroid (hypo/hyper)

Please list any other conditions not mentioned

_____

_____

Past Surgical History *(check all procedures that apply)*

- Appendectomy
- Coronary artery bypass (*open heart)*
- Cholecystectomy (*removal of gallbadder)*
- Gastric bypass
- Hysterectomy (*removal of uterus)*
- Joint repair/replacement (*i.e hip, knee,shoulder)*
- Nephrectomy (*removal of kidney)*
- Spinal surgery
- Splenectomy (*removal of spleen)*

Please list any other procedures not mentioned above: _____

_____

Social History Yes/ How much or often	No
Do you smoke tobacco?	
Do you drink alcohol?	
Have you ever struggled with addiction? If yes, have you been sober?	

Name _____ Date of Birth _____

Family History (*please indicate first degree relatives only)*

Anemia
Asthma
Blood clot *(DVT/PE)*
Coronary artery disease (*Heart attack)*
COPD/emphysema
Cancer
Chronic kidney disease
Chronic liver disease/cirrhosis
Congestive heart failure
Depression
Dementia
Diabetes Type I
Diabetes Type II
Hypertension *(High blood pressure)*
Hyperlipidemia (*High cholesterol)*
Osteoporosis
Seizure
Skin condition
Stroke
Thyroid (hypo/hyper)

Would you be interested in learning more about *(check all that apply)***:**

Botox Injections
Foot and ankle care/peripheral Neuropathy
IV therapy (fluid hydration, vitamins)
Skin care products

Anything else you would like to share with the provider? _____

_____

How did you hear about us? _____

Extended Auth
I hereby authorize Cutting Edge Foot & Ankle, PLLC to furnish information to insurance carriers concerning my illness and treatments, and I hereby assign to Cutting Edge Foot and Ankle Clinic, PLLC all payments for medical services rendered to myself or my dependents. I am aware that it is my obligation to know my insurance company's policies and that I am responsible for any payment if I have not fulfilled their requirements. I also acknowledge the receipt of HIPAA privacy policy.

Signature: _____**Date**: _____

Consent for Treatment
I hereby request and voluntarily consent to such office care, including routine diagnostic procedures and medical treatment as may be deemed necessary by Cutting Edge Foot & Ankle, PLLC and/or his designees.

Signature: _____ **Date:** _____

Cutting Edge
Foot And Ankle Clinic

MEANINGFUL USE QUESTIONNAIRE

We collect this information from all of our patients and use it to track quality of care. This information goes into your medical record and is confidential.

Today's Date:_____

Patient Name:_____DOB:_____

Gender: ___ Male ___Female ___I decline to answer

Race: ___White/Caucasian ___American Indian ___ Asian
___ Black/African American ___ Native Hawaiian/Pacific Islander
___ Other_____
_____I decline to answer the question above

Ethnicity: ____Hispanic or Latino _____Non-Hispanic or Latino
_____ Other_____
_____ I decline to answer the question above

Language: ____ English ___Spanish ___French ___ Russian
___Italian ___Dutch ___Portuguese
___Other_____
_____ I decline to answer the question above

What is meaningful use?

The Federal government requires us to capture this information to improve health outcomes in the following areas: Improve the quality of care, efficiencies, and safety in treating patients Reduce health disparities Engage patients and families Improve care coordination Improve population and public health Guarantee adequate privacy and security protection of PHI

Consent Form
Giving permission for a relative/friend/carer to discuss a patient's confidential information

Cutting Edge Foot and Ankle Clinic
3443 Dickerson Pike
Nashville, TN 37207

I……

(Enter the full name and date of birth of the patient)

Hereby give my permission for:.....

Relationship to the patient……

Address:.....

To discuss my confidential medical information (listed below) held at the Practice with the practice staff, on my behalf (please tick applicable boxes below)

- ☐ Nail/Callous/Corn Care
- ☐ Wound Care
- ☐ Medical conditions
- ☐ Other issues (please add).....

Name of Patient……

Address:.....

Signature:.....Date:.....