Triad Foot & Ankle Center

Partnering for exceptional care.

PATIENT INFORMATION SHEET:

LAST NAME: _____ FIRST NAME/MI: _____

ADDRESS: _____ CITY: _____

STATE: _____ ZIP CODE: _____ SOCIAL SECURITY #: _____

HOME: _____ CELL: _____ WORK: _____

SEX: M F BIRTHDATE: _____ MARITAL STATUS: SINGLE__ MARRIED __ WIDOWED__ OTHER__

EMPLOYER NAME: _____ FULL TIME/PART TIME

EMAIL ADDRESS: _____

INSURANCE NAME: _____ INSURANCE ID #: _____ GROUP #: _____

POLICY HOLDERS NAME: _____ POLICY HOLDER'S DOB: _____

RELATIONSHIP TO PATIENT: _____

RESPONSIBLE PARTY (GUARANTOR) NAME: _____ DOB: _____

ADDRESS: _____ PHONE NUMBER: _____

RELATIONSHIP TO PATIENT: _____

PRIMARY CARE PHYSICIAN: _____ PHONE NUMBER: _____

EMERGENCY CONTACT: _____ PHONE NUMBER: _____

RELATIONSHIP TO PATIENT: _____

CONE HEALTH MEDICAL GROUP

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PATIENT HEALTH HISTORY

PATIENT NAME: _____ **DOB:** _____

AGE _____ **GENDER** _____ **HEIGHT** _____ **WEIGHT** _____ **SHOE SIZE** _____

FAMILY PHYSICIAN: _____ **DATE OF LAST VISIT:** _____

WHY ARE YOU HERE TODAY? _____

_____

_____

_____

ANSWER YES or NO: **Are you pregnant?** _____ **Do you have HIV?** _____

LIST PAST SURGERIES: _____

_____

_____

_____

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ARE YOU EXPERIENCING ANY OF THE FOLLOWING:

CONSTITUTION
- ○ NONE
- ○ APPETITE CHANGES
- ○ ACTIVITY CHANGES
- ○ FEVER
- ○ CHILLS
- ○ SWEATING
- ○ FATIGUE
- ○ WEIGHT CHANGES

ENT
- ○ NONE
- ○ SINUS PROBLEMS
- ○ SORE THROAT
- ○ TROUBLE SWALLOWING
- ○ HEARING LOSS
- ○ RINGING IN EARS
- ○ SNEEZING
- ○ EAR PAIN

EYES
- ○ NONE
- ○ EYE ITCHING
- ○ EYE PAIN
- ○ EYE REDNESS
- ○ VISUAL DISTURBANCE

RESPIRATORY
- ○ NONE
- ○ DIFFICULTY BREATHING
- ○ CHEST TIGHTNESS
- ○ COUCH/WHEEZING
- ○ SHORTNESS OF BREATH

CARDIOVASCULAR
- ○ NONE
- ○ CHEST PAIN
- ○ LEG SWELLING
- ○ PALPITATIONS
- ○ CALF PAIN WITH WALKING

GASTROINTESTINAL
- ○ NONE
- ○ BLOATING
- ○ ABDOMINAL PAIN
- ○ BLOOD IN STOOL
- ○ CONSTIPATION
- ○ DIARRHEA
- ○ NAUSEA
- ○ VOMITING

ENDOCRINE
- ○ NONE
- ○ COLD INTOLERANT
- ○ HEAT INTOLERANT
- ○ EXCESSIVE THIRST
- ○ INCREASE URINATION

GENITOURINARY
- ○ NONE
- ○ DIFFICULTY URINATING
- ○ BLOOD IN URINE
- ○ FREQUENCY
- ○ URGENCY

IMMUNE/ALLERGY
- ○ NONE
- ○ FOOD ALLERGY

SKIN
- ○ NONE
- ○ COLOR CHANGE
- ○ RASH
- ○ OPEN SORES
- ○ CHANGE IN NAILS
- ○ THICK SCABS

MUSCULOSKELETAL
- ○ NONE
- ○ JOINT PAIN
- ○ RASH
- ○ BACK PAIN
- ○ DIFFICULTY WALKING
- ○ MUSCLE PAIN

NEUROLOGICAL
- ○ NONE
- ○ DIZZINESS
- ○ HEADACHES
- ○ LIGHT HEADEDNESS
- ○ NUMBNESS
- ○ SEIZURES
- ○ TREMORS
- ○ WEAKNESS

HEMATOLOGIC
- ○ NONE
- ○ SWOLLEN LYMPH
- ○ BRUISE EASILY
- ○ SLOW TO HEAL

PSYCHIATRIC
- ○ NONE
- ○ BEHAVIOR PROBLEMS
- ○ CONFUSION/ HALLUCINATIONS

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PATIENT MEDICATION LIST

Date _____ **MR #:** _____

PATIENT NAME: _____ **DOB:** _____

Pharmacy Name _____ **Phone #** _____

Medication	Medication
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

ALLERGIES: _____ **NONE (No Known Allergies)** _____ **SEASONAL ALLERGIES**

____PENICILLIN	____SULFA	____IODINE	____ASPIRIN	____ANESTHETICS
____LATEX	____CODEINE	____DEMEROL	____DARVOCET	____CORTISONE
____ADHESIVE TAPE	____FOOD	____ENVIRONMENTAL	____OTHER _____	

TYPE OF REACTIONS _____

_____

_____

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CONE HEALTH MEDICAL GROUP

DESIGNATED PARTY RELEASE

We request that you complete this form when consenting for us to leave detailed verbal information (results of labs, x-rays, prescription refills, etc.) on your home answering machine, voice mail at work, cell phone, or with another party that you choose to designate.

This form does not allow copies of your medical records to be released. To release copies of your medical records you must complete a Request & Authorization for Use/Disclosure of Protected Health Information form.

(Note: The "Health Care Providers Guide: Communicating with a Patient's Family, Friends or Others Involved in the Patient's Care," the U.S. Dept. of Health and Human Services, Office for Civil Rights, provides the following information. Even though HIPAA requires health care providers to protect patient privacy, providers are permitted, in most circumstances, to communicate with the patient's family, friends, or others involved in their care or payment for care, without obtaining written authorization from the patient. You can find more information about HIPAA at this website: http://www.hhs.gov/ocr/hipaa.)

Patient name (PRINT): _____ **DOB:** _____

Today's Date _____

At my request, I authorize: ☐ **All Cone Health Medical Group Practices, or** ☐ **Only this specific practice (specify):** _____**, to verbally disclose my protected health information, as needed to (enter name of person(s)/entity who may be allowed to receive your protected health information):**

Name: _____ **Name:** _____

Address: _____ **Address:** _____

City/State/Zip: _____ **City/State/Zip:** _____

Phone Number: _____ **Phone Number:** _____

Relationship to patient: _____ **Relationship to patient:** _____

At my request, I authorize: ☐ **All Cone Health Medical Group Practices, or** ☐ **Only this specific practice (specify)**_____**, to communicate my protected health information to me via the following methods:**

☐ **Leave detailed message on my home answering machine (phone #** _____**)**

☐ **Leave detailed message on my voice mail at work (phone #** _____ **ext:** _____**)**

☐ **Leave detailed message on my cell phone voice mail (phone #** _____ **ext:** _____**)**

Signature: _____ **Date:**_____

*******IMPORTANT NOTICE BELOW********

PROCEDURE TO CANCEL THIS AUTHORIZATION:

I understand that I may revoke this authorization at any time in writing. However, if I revoke this authorization, I also understand that the cancellation will not affect any action taken in reliance on this authorization before receipt of the written notice of cancellation.

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FMLA AND DISABILITY FORMS

For all forms that are requesting to be completed there is a $25.00 charge for all FMLA and Disability paperwork completed by **Triad Foot & Ankle Center.**

Blank forms will not be accepted-personal information must be completed before requesting they be completed.

The turnaround time for all forms is normally within 14 business days.

MEDICAL RECORDS REQUEST

For all Medical Records Request, there is also a $.75 a page charge required. For every request the patient will need to complete a Medical Records Release form (provided by our office). The turnaround time for all forms is normally within 14 days.

Thank you for your help and consideration.

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OFFICE CANCELLATION POLICY

Please be aware, if an appointment is not cancelled at least 24 hours in advance you will be charged a fee of $50.00.

We have reserved that appointed time and room just for you. Please give us a 24 hour notice if you are not able to make your appointment.

Thank you for your help and consideration.

Triad Foot & Ankle Center

We are excited to offer MyChart to provide you online access to important information in your electronic medical record. We want to make it easier for you to view your health information - all in one secure location - when and where you need it. We expect MyChart will enhance the quality of care and service you experience.

With this health and wellness tool, you will be able to:

- View your test results.
- Request appointments.
- Try a convenient Cone Health e-Visit for certain non-urgent, minor symptoms. Go online when many physician practices are closed to receive a treatment plan within an hour.
- Send a message securely through MyChart to your care team.
- View your medical history, allergies, medications and immunizations.
- Conveniently print your information such as medication lists.

If you have a MyChart account with another health system, you will still need to establish a MyChart account with Cone Health.

If you are age 18 or older and want a member of your family to have shared access to your record, you must provide written consent by completing a form. You can locate this online at **mychart.conehealth.com** or request it from our staff. Please speak to our clinical staff about guidelines regarding MyChart accounts for patients younger than age 18.

Also download the MyChart app! Go to the app store on your mobile device and search "MyChart." Open the app, select Cone Health and log in with your MyChart username and password.

As you activate your MyChart account and need any technical assistance, please call the MyChart technical support line at (336)83-CHART (336-832-4278).

Please contact your physician's office if you have health-related questions. If you have a medical emergency, call 911. Thank you for using MyChart as your new health and wellness resource!

eVisits
MyChart. My Visit. My Way.