Uniquely Connected. For life.℠
HERITAGE VALLEY HEALTH SYSTEM

FOOT & ANKLE

Kimberlee Hobizal, DPM
Tresa Wize, DPM
Specializing in Reconstruction & Trauma

Patient Information Form

Name: _____ Birth Date: _____ Male __ Female __
Last first middle

Address: _____ Telephone # _____/_____
Street City State Zip Home Cell

Marital Status: S __ M__ W__ Sep__ Div__ Social Security # _____ Occupation _____

Employer Name and Address: _____

Name of Emergency Contact: _____ Telephone # _____

Race: American/AK Indian __ Black/African American__ Asian/Pacific Islander__ Hispanic__
White/Caucasian__ Unknown/Decline__

Ethnicity: Not of Hispanic Origin__ Hispanic Origin__ Unknown/Decline__

Will patient be best serviced in a language other than spoken English? Yes__ No__

If yes, Please Specify_____

Spouse, Parent Or Guardian Information:

Name: _____ M__ F__ Birth Date: _____
Last First Middle

Address: _____ Telephone # _____
Street City State Zip Spouse__ Parent__ Other__

Social Security # _____ Employer Name and Address: _____

* If Automobile, Job Injury or Accident, List Responsible Party or Insurance as Primary and Health Insurance as Secondary

Insurance Information: Primary Insurance Name: _____

Address: _____ Telephone # _____

Who Owns the Policy? _____ Birth Date: _____ Effective Date: _____

ID # _____ Group # _____ Relationship: Self__ Spouse __ Parent __ Other __

79 Wagner Road, Suite 103
Monaca PA 15061
878-439-3598

Second or Co-Insurance Name: _____

Address: _____ Telephone # _____

Who Owns the Policy? _____ Birth Date: _____ Effective Date: _____

ID # _____ Group # _____ Relationship: Self__ Spouse__ Parent__ Other __

Health Questions:

Briefly Describe Why You Are Visiting Our Office: _____

If Condition Is Due To An Accident, Please Describe Nature Of Accident: _____

Date Of Injury: _____ Time Of Injury: _____ Place Of Injury: _____

Return To Work Date: _____ Did You Have X-Rays Done For This Condition? Yes__ No__

Date Of X-Rays: _____ Where X-Rays Were Done: _____

Primary Care Physician Name And Address: _____ Telephone# _____

Pharmacy Name: _____ Telephone # _____

Assignment And Release:

AUTHORIZATION FOR RELEASE OF INFORMATION: I authorize the release of any medical information to insurance carriers (including Medicare) concerning my treatment necessary to process this claim to HVMG Foot and Ankle. I understand that any false claims, statements, documents or concealment of material fact, may be prosecuted under applicable federal and state laws.

AUTHORIZATION FOR ASSIGNMENT OF PAYMENTS: I authorize payment of medical benefits to HVMG Foot and Ankle for services rendered to me. I understand that I am responsible for all charges, INCLUDING CO-PAYS AND CHARGES NOT COVERED BY INSURANCE.

I UNDERSTAND THAT REFERRAL FOR HMO PARTICIPANTS ARE THE PARTICIPANT'S RESPONSIBILITY. IF NO AUTHORIZATION WAS APPROVED PRIOR TO SERVICE, I ACCEPT FINANCIAL RESPONSIBILITY FOR SERVICES RENDERED. THIS PAYMENT WILL BE DUE AT TIME OF SERVICE.

If I have a liability claim for my medical services, such as auto, worker's compensation, accident, etc., I understand that I am ultimately liable for services rendered to me and I agree to pay directly to HVMG Foot and Ankle should my claim with the insurance carrier and/or policy holder be denied or challenged.

CONSENT TO TREATMENT: I authorize treatments to myself, or as an authorized person of the patient, by HVMG Foot and Ankle including employees therein.

CONSENT TO CONTRACT BY CELL PHONE OR TEXT: I authorize HVMG Foot and Ankle or its agents to contact guarantor and/or patient by cell phone or text for purposes of notifying appointments, outstanding bills, test results, and other medical practice activities. I understand I can revoke this at any time in writing.

(X) _____ Date _____

(Signature of patient or authorized person)

Uniquely Connected. For life.℠
HERITAGE VALLEY HEALTH SYSTEM℠

MEDICAL HISTORY

Patient Name:	Height:	Weight:
Family Physician:	Phone Number:	

Please list any medical conditions that you have. If none, please check none. ☐ None

Do you have Sleep Apnea? ☐ No ☐ Yes

Do you use CPAP/BIPAP? ☐ No ☐ Yes

If so, what are your settings for your machine?_____

Do you have Diabetes? ☐ No ☐ Yes

Do you have OR have you ever been treated for cancer? ☐ No ☐ Yes, type: _____

Do you take blood thinners (including aspirin)? ☐ No ☐ Yes, which one _____

Please list any surgeries or hospitalizations you have had in the past. If none, please check none. ☐ None

Please list all medications you are currently taking. (Include birth control pills, vitamins, supplements, etc.)
Please include strength (how many milligrams & how many times a day you take it). If none, please check none. ☐ None

Medication	Dose	Frequency	Medication	Dose	Frequency

Please list all medications to which you are allergic and type of reaction you had. If none, please check none. ☐ None

Are you allergic to latex? ☐ Yes ☐ No

Family History

My family members have a history of the following medical problems. Check yes or no.

Asthma	☐ Yes	☐ No	Cancer	☐ Yes	☐ No
Bleeding problems	☐ Yes	☐ No	Diabetes	☐ Yes	☐ No
Blood vessel disease (circulation problems)	☐ Yes	☐ No	High blood pressure	☐ Yes	☐ No
			Seizures	☐ Yes	☐ No

PLEASE CONTINUE AND COMPLETE OPPOSITE SIDE OF PAGE.

Please circle the correct answer below:

Have you ever been tested for the Aids Virus (HIV)? Yes No If yes, what were the results: Positive or Negative

Have you been diagnosed with Hepatitis? Yes No If yes: A B C

Do you smoke? Yes No If yes, how much per day?

Have you ever smoked? Yes No

Do you drink alcohol? Yes No If yes, how much per day?

Do you use social drugs? Yes No If yes, what and how often?

Have you ever been treated for alcoholism or drug abuse? If so, what? and when?

Are you pregnant or have any reason to think you might be? Yes No

Review of Systems

Do you have or have had any of the following? Check yes, no or ongoing.

Anxiety	☐ Yes	☐ No	☐ Ongoing	Nausea or Vomiting	☐ Yes	☐ No	☐ Ongoing
Arthritis	☐ Yes	☐ No	☐ Ongoing	Pacemaker	☐ Yes	☐ No	☐ Ongoing
Artificial Valve	☐ Yes	☐ No	☐ Ongoing	Defibrillator	☐ Yes	☐ No	
Bleeding Tendencies	☐ Yes	☐ No	☐ Ongoing	Past Stroke	☐ Yes	☐ No	☐ Ongoing
Blood Transfusions	☐ Yes	☐ No	☐ Ongoing	Prolonged Bleeding from Surgery	☐ Yes	☐ No	☐ Ongoing
Bone Disease	☐ Yes	☐ No	☐ Ongoing	Rectal Bleeding	☐ Yes	☐ No	☐ Ongoing
Chest Pain	☐ Yes	☐ No	☐ Ongoing	Rheumatic Heart Disease	☐ Yes	☐ No	☐ Ongoing
Constipation	☐ Yes	☐ No	☐ Ongoing	Seizures	☐ Yes	☐ No	☐ Ongoing
Depression	☐ Yes	☐ No	☐ Ongoing	Severe Nosebleeds	☐ Yes	☐ No	☐ Ongoing
Diarrhea	☐ Yes	☐ No	☐ Ongoing	Shortness of Breath	☐ Yes	☐ No	☐ Ongoing
Epilepsy	☐ Yes	☐ No	☐ Ongoing	Stomach Pain	☐ Yes	☐ No	☐ Ongoing
Heart Attack in Past	☐ Yes	☐ No	☐ Ongoing	Think I'm at High Risk for AIDS	☐ Yes	☐ No	☐ Ongoing
Heart Disease	☐ Yes	☐ No	☐ Ongoing	Ulcer Disease	☐ Yes	☐ No	☐ Ongoing
Heartburn	☐ Yes	☐ No	☐ Ongoing	Ulcers in Past	☐ Yes	☐ No	☐ Ongoing
Heartburn, Frequent	☐ Yes	☐ No	☐ Ongoing	Urination, Frequent	☐ Yes	☐ No	☐ Ongoing
High Blood Pressure	☐ Yes	☐ No	☐ Ongoing	Urination, Painful	☐ Yes	☐ No	☐ Ongoing
Irregular Heartbeat	☐ Yes	☐ No	☐ Ongoing	Urination, Slow	☐ Yes	☐ No	☐ Ongoing
Jaundice	☐ Yes	☐ No	☐ Ongoing	Veneral Disease	☐ Yes	☐ No	☐ Ongoing
Kidney Disease	☐ Yes	☐ No	☐ Ongoing	Weight Loss	☐ Yes	☐ No	☐ Ongoing
Kidney Stones	☐ Yes	☐ No	☐ Ongoing				
Liver Disease	☐ Yes	☐ No	☐ Ongoing				
Lung Disease	☐ Yes	☐ No	☐ Ongoing				

I hereby state that the above information is true and correct to the best of my knowledge.

Signature

Date

Print Name