VALLEY VIEW FOOT & ANKLE CENTER, PLLC
DR BRYAN BLANCK DPM, FACFAS

PATIENT REGISTRATION – PLEASE PRINT CLEARLY

NAME: LAST FIRST MIDDLE	SEX	MARITAL STATUS { } S { } M { } D { } SEP { } W

MAILING ADDRESS:	CITY ST	ZIP CODE

DATE OF BIRTH:	SOCIAL SECURITY #	E-MAIL ADDRESS:

HOME PHONE:	CELL PHONE:	WORK PHONE:
EMPLOYER:	REFERRED BY:	PRIMARY CARE DOCTOR:
SPOUSE'S NAME:	SPOUSE'S DOB:	SPOUSE'S SOCIAL SECURITY #
SPOUSE'S EMPLOYER:	SPOUSE'S WORK PHONE:	SPOUSE'S CELL PHONE:

BILLING AND INSURANCE INFORMATION

BILL TO: LAST NAME FIRST M	REALTIONSHIP TO PATIENT

ADDRESS	CITY	ST	ZIP CODE

EMPLOYER:	EMP PHONE NO:	HOME NO:	CELL NO:
PRIMARY INSURANCE NAME & ID NO:	SUBSCRIBER NAME:	SUBSCRIBER DOB:	SUBSCRIBER SSN:
SECONDARY INS NAME & ID NO:	SUBSCRIBER NAME:	SUBSCRIBER DOB:	SUBSCRIBER SSN:
TERTIARY INS NAME & ID NO:	SUBSCRIBER NAME:	SUBSCRIBER DOB:	SUBSCRIBER SSN:

RELEASE OF MEDICAL INFORMATION FOR BILLING PURPOSES

*I hereby authorize **VALLEY VIEW FOOT & ANKLE CENTER, PLLC to release medical information to my insurance carrier(s) for the sole purpose of obtaining payment for my medical care, I agree that o copy of this release may be used in place of the original.**

PAYMENT FOR MEDICAL SERVICES

*I hereby assume financial responsibility for all charges incurred for services rendered. I understand that I am responsible for all copayments, co-insurances, deductibles, and non-covered charges paid in accordance with the benefits of my current insurance policy at the time services are rendered. It is further agreed that in the event I fail to pay upon demand, should my account be referred to a collection agency and or attorney, I accept full responsibility to pay all collection costs not to exceed 30% and interest of 1.5% per month not to exceed 18% per annum and reasonable court costs.

*I hereby authorize payment for all medical insurance benefits which are payable under the terms of my insurance policy, to be paid directly to Valley View Foot & Ankle Center, PLLC.

*I understand I may be billed a no show fee for a missed or cancelled appointment without a 24 hour notice.

*I understand that all Durable Medical Equipment (DME) and Retail Items dispensed to me are non-refundable and cannot be returned unless there is a factory defect with the product at which time Valley View Foot & Ankle Center, PLLC will replace the defective item with a new item. I understand that my insurance has been billed for these items and do not hold Valley View Foot & Ankle Center, PLLC responsible for the disposal of any unwanted items.

*I understand that my insurance company may be billed for a phone consultation with my physician and I may incur a copayment for this service.

_____ _____

PATIENT OR LEGAL GUARDIAN SIGNATURE DATE

VALLEY VIEW FOOT & ANKLE CENTER, PLLC

PATIENT NAME: ***DR BRYAN BLANCK DPM, FACFAS***

HIPAA PATIENT RELEASE

HIPAA is an acronym for the Health Insurance Portability & Accountability Act of 1996 (a federal law). Of significant concern to healthcare organizations is the Administrative Simplification section of the Act, which requires healthcare organizations to comply with specific rules regarding:

- Unique Identifiers for health plans, providers, individuals and employers
- Healthcare Transaction & Code Sets for transmitting data electronically
- Privacy Regulations over disclosure and use of health information
- Security Regulations over protections of electronic health information

All of these rules have been developed by the Department of Health & Human Services and will become "final" in a staged manner – healthcare organizations will generally have 24 months to achieve compliance, as each rule becomes final.

It is the office policy of Valley View Foot & Ankle Center, PLLC to not release confidential and/or unauthorized information by home telephone, answering machine, work telephone, voice mail, cell phone and/or pager. Whenever returning telephone calls and the answering machine picks up, we do not leave a message if the name or telephone number is not on the recorded message to identify the residence. Also, information will not be left with an unauthorized person who may answer the telephone.

If you would like to have information released to someone other than yourself please complete the following:

I authorize Valley View Foot & Ankle Center, PLLC to leave medical information pertaining to my care by the following methods and will assume responsibility to notify them whenever this information changes:

Home Telephone_____YES _____NO
Work Telephone _____YES _____NO
Cell Phone _____YES _____NO
Cell Ph Text Mess_____YES _____NO

Answering Machine_____YES _____NO
Work Voice Mail _____YES _____NO
Cell Voice Mail _____YES _____NO
Email address _____YES _____NO

Please list the name & relationship of the individual(s) you have authorized to receive this information:

Name:_____ Relation:_____ Phone: _____

Name:_____Relation:_____Phone: _____

Name:_____Realtion:_____Phone:_____

Fax medical records for referrals to another entity _____YES _____NO

PATIENT NAME: _____

SIGNATURE: _____ DATE:_____

VALLEY VIEW FOOT & ANKLE CENTER, PLLC

PATIENT NAME: ***DR BRYAN BLANCK DPM, FACFAS***

INITIAL COMPREHENSIVE FOOT & ANKLE QUESTIONNAIRE

Please complete this form before your first appointment at Valley View Foot & Ankle Center. Your careful answers will help us to understand your foot & ankle problem and design the best treatment plan for you.

NAME:_____DOB: _____ AGE:_____

HEIGHT:_____ WEIGHT:_____SHOE SIZE:_____SHOE WIDTH:_____

Family Physician:_____Referring Doctor:_____

Endocrinologist:_____ Cardiologist:_____

What Pharmacy do you use:_____Location:_____

What Home Health Agency do you use:_____Location:_____

How did you hear about our office:_____

**Where is your pain located? (CHECK ALL THAT APPLY) How long have you been experiencing your current problem?_____

LEFT	RIGHT
{ } Heel / Arch Pain	{ } Heel / Arch Pain
{ } Ankle Pain (outside inside front back)	{ } Ankle Pain (outside inside front back)
{ } Foot Pain (top bottom)	{ } Foot Pain (top bottom)
{ } Toe Problem (big 2nd 3rd 4th 5th)	{ } Toe Problem (big 2nd 3rd 4th 5th)

Additional problems not listed above:_____

How did this injury occur?_____

IS THIS AN ON THE JOB INJURY? YES NO If yes, date of injury_____

Is this injury due to a MOTOR VEHICLE accident or other third party? YES NO If yes, date of injury_____

Name & phone # of attorney representing you for this injury:_____

**HOW MUCH PAIN DO YOU HAVE? WHAT IS THE SEVERITY?_____

**TIMING OF PROBLEM /PAIN: HOW OFTEN DO YOU HAVE YOUR PAIN? (CHECK ONLY ONE)

{ } Constantly (100% of time) { } Nearly Constantly (60-95% of time) { } Intermittently (30-60% of time) { } Occasionally (less than 30% of time)

In general, during the past month, when has your pain / problem been the worst? (check only one)
{ } MORNING { } NIGHT { } AFTERNOON { } EVENING { } NO TYPICAL PATTERN

**SYMPTON QUALITY: HOW WOULD YOU DESCRIBE YOUR PAIN? (CHECK ALL THT APPLY AND CIRCLE THE DOMINANT QUALITY)
{ } Burning { } Sharp { } Cutting { } Throbbing { } Electric { } Cramping { } Dull/Aching { } Pressure-like
{ } Shooting { } Pins and needles { } Walking on a pebble { } Pain on the first step of the day { } Other

PATIENT NAME:_____

RELIEVING AND AGGRAVATING FACTORS:

How does the following affect your pain? (answer for each activity by checking only one of the boxes)

ACTIVITY	DECREASE	NO CHANGE	INCREASE
STANDING			
SITTING			
WALKING			
EXERCISE			
ELEVATION			

Your pain is **AGGRAVATED** by: { } Weather { } Shoes { }Touch Pain is **RELIEVED** by: { } Heat { } Cold { } Rest { } Compression { } Meds

ACTIVITIES AND YOUR PAIN:

How many blocks are you able to walk? # of blocks:_____ Less than 1 block_____
For walking assistance I use a: { } CANE { } WALKER { }WHEELCHAIR { } No Assistance Needed

Check all of the daily living activities listed below that you are *NOT* able to perform:
{ }Going to Work { }Household Chores { }Yard Work { }Wearing Shoes { }Exercising { }Shopping { }Participating in Recreational Activities

YOUR PAST MEDICAL HISTORY

HEALTH PROBLEM	YES	NO	HEALTH PROBLEM	YES	NO
ANEMIA			HEART ATTACK		
ANGINA / CHEST PAIN			HEART CONDITION		
ASTHMA			HEART VALVE ISSUES		
BLEEDING DISORDER			HIGH BLOOD PRESSURE		
BLOOD CLOTS (DVT)			HIGH CHOLESTEROL		
BLOOD THINNER			INFECTION PRONE		
BONE FRACTURE			KIDNEY CONDITION		
CANCER			LIVER CONDITION		
DEPRESSION			MENOPAUSE		
DIABETES			OBESITY		
EMPHYSEMA			OSTEOMYELITIS		
EPILEPSY / SEIZURES			PARKINSON DISEASE		
FAINTING			RAYNAUDS		
FIBROMYALGIA			RHEUMATOID ARTHRITIS		
FOOT DISORDER			SICKLE CELL		
FOOT SURGERY			STROKE		
G.I. CONDITION			ULCER		
GOUT			VASCULAR DISEASE		
LOW THYROID – HIGH THYROID (please circle)			VASCULAR NECROSIS		

FAMILY MEDICAL HISTORY

HEALTH PROBLEM	MOM	DAD	HEALTH PROBLEM	MOM	DAD
ANEMIA			HEART ATTACK		
ASTHMA			HIGH BLOOD PRESSURE		
BLEEDING DISORDER			HIGH THYROID – LOW THRYROID		
BLOOD CLOTS (DVT)			KIDNEY CONDITION		
CANCER			LIVER CONDITION		
DEPRESSION			STROKE		
DIABETES			OBESITY		
EMPHYSEMA			PARKINSON DISEASE		
EPILEPSY / SEIZURES			RHEUMATOID ARTHRITIS		
G.I. CONDITION			SICKLE CELL		
GOUT			VASCULAR DISEASE		

Please list any other condition(s)_____

********DIABETICS PLEASE ANSWER THE FOLLOWING QUESTIONS*******

How long have you had diabetes?_____What is your usual FSBS?_____How many times daily do you check your sugar?_____
Check your type of diabetes: _____Type I _____Type II (Insulin) _____Type II (Non-Insulin) _____Type II (Diet Controlled)

VALLEY VIEW FOOT & ANKLE CENTER, PLLC

Patient Name: *DR BRYAN BLANCK DPM, FACFAS*

PAST SURGICAL HISTORY: Please list any hospitalizations / surgeries with approximate dates.

Surgeries / Injuries	DATE	Type of Procedure	Surgeries / Injuries	DATE	Type of Procedure
Abdominal Surgery			CABG (Heart Bypass)		
Amputation			Cardiac Surgery		
Angioplasty			Cancer Surgery		
Ankle Surgery			Cataract Surgery		
Appendectomy			Cholecystectomy		
Artificial Joint			Cosmetic Surgery		
Back Surgery			Foot Surgery		
Biopsy			GYN Surgery		
Bowel Surgery			Vascular Surgery		

List other surgeries:_____

ALLERGIES: WHAT ALLERGIES DO YOU HAVE AND WHAT IS YOUR REACTION TO THEM?

ALLERGY	TYPE OF REACTION	ALLERGY	TYPE OF REACTION
ASPIRIN		AMPICILLIN	
CODEINE		CORTISONE	
DEMEROL		LATEX	
MORPHINE		TAPE	
NOVOCAINE		GLOVE POWDER	
TYLENOL		IODINE (SEAFOOD)	
NSAIDS		EGGS	
PENICILLIN		OTHER	
SULFA DRUGS		OTHER	

CURRENT MEDICATIONS AND DOSAGES (PLEASE PRINT)

NAME OF MEDICATION	DOSAGE / STRENGTH	HOW OFTEN DO YOU TAKE IT

VALLEY VIEW FOOT & ANKLE CENTER, PLLC

Patient Name: *DR BRYAN BLANCK DPM, FACFAS*

***SOCIAL HISTORY*:**

- **EDUCATION: Your highest education level achieved.**

{ } Graduate or Professional Training { } College Graduate { } Partial College { } High School Graduate
{ } Technical Training { } GED { } Partial High School { } Partial Jr High

- **EMPLOYMENT: Your current or most recent occupation.**

{ } Semi Skilled or Unskilled (Waitress, Assembler) { } Skilled Technical or Clerical (Carpenter, Secretary)
{ } Business or Managerial { } Professional { } Homemaker { } Other:_____

- **CURRENT EMPLOYMENT STATUS:**

{ } Employed Full Time { } Employed Part Time { } Unemployed { } Retired { } Student { } Homemaker
If you are unemployed or employed part time, is this due to your present foot condition? YES NO
If you are currently unemployed, indicate how long you have been off work:_____

- **FAMILY LIFE: (Please specify living arrangements)**

{ } Living alone { } Living with spouse/partner { } Living with spouse/partner and children { } Living with children
{ } Living with friends { } Living with parents { } Living with other

SUBSTANCE ABUSE:

Have you ever been a smoker? { } YES –Current { } YES – Former { } NO – Never
How many packs per day? _____ How Long?_____ Date Quit?_____
Do you have a history of Alcoholism: { }YES { }NO { }Current problem Prescription Drug Abuse: { }YES { }NO { }Current problem
Illegal substance abuse: { } YES { } NO { } Current How long has it been since you have abused alcohol or drugs_____

REVIEW OF SYSTEMS: Please mark all that apply

CONSTITUTIONAL	EYES	CARDIOVASCULAR	MUSCULOSKELETAL
{ } General Good Health	{ } Wear Glasses/Contacts	{ } Chest Pain	{ } Muscle pain/cramps
{ } Weight Loss or Gain_____lbs	{ } Blurred/Double Vision	{ } Palpitations	{ } Stiffness/Swelling Joints
{ } Night Sweat/Fever	{ } Eye Disease or Injury	{ } Heart Trouble	{ } Joint Pain
{ } Fatigue	{ } Glaucoma	{ } Swelling Hands/Feet	{ } Difficulty Walking

EARS/NOSE/THROAT/MOUTH	GASTROINTESTINAL	RESPIRATORY	NEUROLOGICAL	PSYCHIATRIC
{ } Hearing Loss/Ringing	{ } Nausea/Vomiting	{ } Shortness of Breath	{ } Frequent Headaches	{ } Insomnia
{ } Sinus Problems	{ } Abdominal Pain	{ } Cough	{ } Paralysis/Tremors	{ } Confusion/Memory Loss
{ } Nose Bleeds	{ } Rectal Bleeding	{ } Wheezing/Asthma	{ } Convulsions/Seizures	{ } Depression
{ } Sore Throat/Voice Change	{ } Bowel Problems	{ } Coughing Up Blood	{ } Numbness Tingling	{ } Anxiety

ENDOCRINE	HEMATOLOGIC/LYMPHATIC	ALLERGIES	INTEGUMETARY	GENITOURINARY
{ } Excessive Thirst/Urination	{ } Bruise Easily	{ } Food Allergies	{ } Change in Hair/Nails	{ } Blood In Urine
{ } Thyroid Disease	{ } Slow to Heal	{ } Aspirin Allergies	{ } Rashes or Itching	{ } Kidney Stones
{ } Hormone Problem	{ } Enlarged Glands	{ } Antibiotic Allergies		