

AUNG FOOTHEALTH CLINICS

Barbara J. Aung, DPM

PATIENT NAME _____ AGE _____ SEX _____ DATE OF BIRTH ____/____/____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

HOME PHONE _____ CELL PHONE _____ WORK PHONE _____

If you have e-mail may we contact you? _____ E-Mail address _____

Marital Status _____ Employer _____ Address _____

Primary Physician _____ Referred by _____

INSURANCE BILLING INFORMATION /RESPONSIBLE PARTY

NAME of INSURED _____ Relationship to patient _____

ADDRESS _____ [†] same as above

PRIMARY INSURANCE _____

SUBSCRIBER _____ SS # _____ DOB _____

EMPLOYER _____ ADDRESS _____ PHONE _____

SECONDARY INSURANCE _____

SUBSCRIBER _____ SS # _____ DOB _____

It is my responsibility to pay the Doctor for her services. Payment is due when services are rendered. I understand Aung FootHealth Clinic will file insurance claims for services rendered as a courtesy, and according to our agreement with them. If they are not a provider on my insurance plan, full payment is due at the time of services. I agree to make full and complete payment within 30 days of denial of a claim by my insurance plan. If the account is not paid in full, I agree to pay a monthly account maintenance fee of \$8.00 per month until it is paid in full. I understand I am responsible for any costs related to collection procedures including attorney's fees and court costs. I agree to pay all actual collection fees along with the entire balance due for services received. I AUTHORIZE RELEASE OF MEDICAL INFORMATION FOR INSURANCE CLAIM PURPOSES, AND AUTHORIZE PAYMENT OF INSURANCE BENEFITS TO THIS OFFICE DIRECTLY. Providing incorrect or incomplete information will delay claim filing and may be denied by insurance plan as not timely filing, and I will be responsible for the entire balance if this occurs.

Signature _____ Date _____

I AUTHORIZE BARBARA AUNG, DPM, PC/AUNG FOOTHEALTH CLINIC TO RELEASE ANY DIAGNOSTIC TEST RESULTS AND OTHER PERSONAL HEALTH INFORMATION TO ME PERSONALLY OR TO LEAVE THE INFORMATION ON MY ANSWERING MACHINE AT HOME

Signature _____ Date _____

I AUTHORIZE AUNG FOOTHEALTH CLINIC PERSONNEL TO TALK TO THE FOLLOWING PEOPLE REGARDING MY TEST RESULTS, HEALTH CONDITION OR ACCOUNT BALANCE :

_____ MY SPOUSE _____ MY CHILDREN (EXCLUSIONS: _____)

HEALTH HISTORY

NAME _____ BIRTH DATE ____/____/19____ DATE ____/____/200__

HEIGHT _____ WEIGHT _____ (LBS) OCCUPATION _____

PRIMARY DR. _____ REFERRING DR. _____

(CC) MAIN REASON(S) FOR VISIT :

(1) _____

(HPI) History Present Illness

Location: _____ R L

Duration: ____ days ____ wks ____ mos ____ yrs

Onset: acute/overnight insidious/slowly

Symptoms

Type: ach/brn/dull/sharp/sore/throb

Area: localized radiating

Course: constant irregular

Worsened by _____

Improved by _____

Previous treatment

Who Dr. _____ Self

What _____

When _____

Outcome _____

(2) _____

(HPI) History Present Illness

Location: _____ R L

Duration: ____ days ____ wks ____ mos ____ yrs

Onset: acute/overnight insidious/slowly

Symptoms

Type: ach/brn/dull/sharp/sore/throb

Area: localized radiating

Course: constant irregular

Worsened by _____

Improved by _____

Previous treatment

Who Dr. _____ Self

What _____

When _____

Outcome _____

(PMH) Past Medical History

ALLERGIES : NONE, hay fever, adhesive tape,

Latex, Iodine dye , Penicillin, Antibiotics: List →

LIST MEDICATIONS CURRENTLY USING:

[Barbara J. Aung, DPM, CWS _____]

Date : ____/____/200__

NAME _____ BIRTH DATE ____/____/19____ DATE ____/____/200__

Hospitalizations & Surgeries:

Appendectomy, Hernia Repair, Tonsilectomy
Childbirth X _____
Fractures/Broken Bones – Screws/Pins/Wires

Heart Bypass - Yr. _____ How Many _____
Leg Bypass – Yr. _____

(ROS) Review Of Systems:

Cardiovascular:

Chest Pain (angina)	YES <input type="checkbox"/>	NO <input type="checkbox"/>	Date Diagnosed _____
Congestive Heart Failure (CHF)	YES <input type="checkbox"/>	NO <input type="checkbox"/>	Date Diagnosed _____
High Blood Pressure (HTN)	YES <input type="checkbox"/>	NO <input type="checkbox"/>	Date Diagnosed _____
Heart Attack (MI)	YES <input type="checkbox"/>	NO <input type="checkbox"/>	Date Last Episode _____
Stroke (CVA or TIA)	YES <input type="checkbox"/>	NO <input type="checkbox"/>	Date Last Episode _____
Blood Clots in Legs	YES <input type="checkbox"/>	NO <input type="checkbox"/>	Date Last Episode _____

Digestive:

Gall Stones Hepatitis:Type: _____ Acid Reflux Stomach Ulcers

Endocrine :

Diabetes	YES <input type="checkbox"/>	NO <input type="checkbox"/>	Date Diagnosed _____	Last A1c _____		
Thyroid	YES <input type="checkbox"/>	NO <input type="checkbox"/>	If Yes :	Hypo(Low) <input type="checkbox"/>	Hyper(High) <input type="checkbox"/>	
Kidney	YES <input type="checkbox"/>	NO <input type="checkbox"/>	On Dialysis	YES <input type="checkbox"/>	NO <input type="checkbox"/>	ESRD <input type="checkbox"/>

Blood : Bleeds or Bruises Easily YES NO | || | Anemia | YES | NO | Date Diagnosed _____ |
| | AIDS or HIV | YES | NO | Date Diagnosed _____ |

Skin : Skin ulcer/non healing wounds YES NO | _____ |

Nervous: Epilepsy YES NO | Date last episode _____ || | Depression | YES | NO | medications helping YES/NO ; NO Meds |
| | Sciatic Nerve Pain | YES | NO | Back Pain YES | NO |
| | Polio | YES | NO | _____ |

Reproductive: Pregnant YES NO | Due Date : _____ |

[Barbara J. Aung DPM,CWS]

Date : ____/____/200__

NAME _____ BIRTH DATE ____/____/19____ DATE ____/____/200__

Lungs: Emphysema YES NO Using Oxygen: _____(Liters)/Minute
Tuberculosis YES NO Date Diagnosed _____
Pneumonia YES NO Date Diagnosed _____

Skeletal:

Arthritis YES NO Type : Rheumatoid / Osteoarthritis / _____
Gout YES NO Date of Last Episode : _____
Cancer YES NO Type _____ Date Diagnosed _____

PFH (Past Family History)

Father Arthritis/Diabetes/Heart Disease/Gout/Depression Living/Deceased _____
Mother Arthritis/Diabetes/Heart Disease/Gout/Depression Living/Deceased _____
Siblings Arthritis/Diabetes/Heart Disease/Gout/Depression Living/Deceased _____

DO YOU NOW HAVE, OR HAVE HAD IN THE PAST YEAR:

Weakness or paralysis	YES	NO	Leg Cramps	YES	NO
Recent Weight changes	YES	NO	Enlarged Veins	YES	NO
Skin Rashes	YES	NO	Seizures	YES	NO
Joint pain or Swelling	YES	NO	Memory Loss	YES	NO
Change in Nails	YES	NO	Poor Coordination	YES	NO
Bruise or bleed easily	YES	NO	Headaches	YES	NO
Broken or Sprained ankle	YES	NO	Dizziness	YES	NO
Swelling of feet/hands/ankles	YES	NO	Labored Breathing	YES	NO
Are you pregnant	YES	NO			

PSH (Past Social History)

Alcohol: None Social Recovering Alcoholic
Tobacco Use: None _____ Packs/Day X _____ # Years Quit Date: _____
Caffeine Drinks : None _____ cups/day

This is a confidential record of your medical history, all information will be kept in the office in a secured location. No information will be given out without your express written permission.

[Barbara J. Aung DPM,CWS _____]

Date : ____/____/200__