ADULT NEW PATIENT PACKET – FOOT & ANKLE

Eau Claire

OakLeaf Clinics - Pine Grove (Stein)

3221 Stein Blvd., Suite 4, Eau Claire, WI 54701

Phone: 715-834-2788 | Fax: 715-834-2845

Turtle Lake

Cumberland Healthcare - Turtle Lake Center

632 US Highway 8, Turtle Lake, WI 54889

Phone: 715-986-202 | Fax: 715-986-2236

Scheduling line: 715-822-7350

REMINDERS

- ☐ Please arrive 15 minutes early to your appointment for check in.
- ☐ Bring this new patient paperwork packet with you.
- ☐ Bring your insurance card to your appointment, every time.
- ☐ Questions about your insurance?
    - Call your employer's Human Resource Department or the phone number listed on your insurance card.
    - It is your responsibility to understand your insurance coverage.
    - Every health care plan varies based on your employer.

Thank you for choosing our office, we look forward to caring for you.

Patient's Legal Name: (Last) ___________________________ (First) _______________________ (MI) ________

Preferred First Name: _____________________________ Maiden/Previous Names: ______________________

SSN: ______________________________ Birthdate: _____________________ ▢Male ▢Female

Address: ___________________________________ City: ___________________ State: ____ Zip: __________

Home Phone: __________________________ Cell Phone: _________________________ Shoe Size: ________

Patient's Employer: _______________________________________ Occupation: _________________________

Emergency Contact Name: ________________________________ Phone Number: ______________________

Email Address: ____________________________ Would you like information on the patient portal? ▢Yes ▢No

Appt. Reminders: ▢Phone Call ▢Text Message (message & data rates may apply) ▢Patient Portal/Email

Please check all that apply: ▢Minor ▢Single ▢Married ▢Divorced ▢Widowed ▢Separated

Race: ▢White ▢Asian ▢Native Hawaiian ▢Other Pacific Islander ▢African American ▢American Indian

▢Alaska Native Language: ▢English ▢Spanish ▢Hmong ▢Other: ______________________________

Ethnicity: ▢Not Hispanic/Latino ▢Hispanic/Latino

Legal Guardian/Parent's Name (If applicable): ______________________________ Phone: _________________

Are you a student? ▢Yes ▢No Name of School/College: ____

Primary Care Provider: ____

How did you hear about OakLeaf Clinics Foot and Ankle? ____

Preferred Pharmacy (include location): ____

Insurance Information: *Required, unless you are self-pay*

<u>Primary</u> Insurance: ___________________________ ID #: ________________ Group #: ___________________

Policy Holder: ________________________ Employer: ______________________ Work Phone: ______________

Relationship to Patient: _______________________ Birthdate: __________________ SSN: _________________

<u>Secondary</u> Insurance: _________________________ ID #: ________________ Group #: ___________________

Policy Holder: ________________________ Employer: ______________________ Work Phone: ______________

Relationship to Patient: _______________________ Birthdate: __________________ SSN: _________________

What foot or ankle concerns would you like to be addressed at your appointment? ________________________

____

When did your condition begin? ______________________________ Was it related to an injury? ▢Yes ▢No

If so, what type of injury? ____

What bothers you most about your foot or ankle? ▢Pain ▢Swelling ▢Instability ▢Deformity

What is your average pain due to your foot and ankle condition?												
☺	0	1	2	3	4	5	6	7	8	9	10	☹
No pain												*Worst pain*

What distance can you walk before your symptoms begin?

▢Unlimited distance ▢4-6 blocks ▢1-3 blocks ▢Less than 1 block

What activities make your symptoms worse?

▢Walking ▢Running ▢Uneven ground ▢Certain shoes ▢Getting up from seated position

Do you participate in sports, outdoor activities, or regular exercise? ___________________________________

Which of the following treatments have you tried?

▢Anti-inflammatory medication (start date/frequency): ____

▢Physical therapy (start date/frequency): ____

▢Steroid injection (date of injection): ____

▢Shoe inserts or orthotics ▢Bracing ▢Surgery: ____

Prior diagnostic studies related to foot or ankle (X-rays, MRI, CT, EMG, vascular studies, etc.):

____

____

List all previous foot or ankle surgeries (include year of surgery, starting with most recent):

____

____

Do you smoke? ▢Yes ▢No How much? ____

Do you use other tobacco products? ▢Yes ▢No How much? _______________________________

Do you drink alcohol? ▢Yes ▢No How often? ____

PAST MEDICAL HISTORY: *Please check all that apply*

	Arthritis		Kidney disease/problems		Anemia
	Diabetes		Radiation therapy		Chemotherapy
	Blood clots		Rheumatic fever		Jaundice (yellowing of skin)
	Heart attack/chest pain		Tuberculosis		Sinus problems
	Stroke		Bleeding tendency		Pneumonia
	Transfusions		Bronchitis		Asthma/wheezing
	Thyroid disease/goiter		High blood pressure		Emphysema
	COPD		Congestive heart disease		Nervous breakdown
	Chicken pox or vaccination		High cholesterol		Depression
	Cancer		Valve replacement		Joint replacement
	Heart murmur		Difficulty sleeping		Headaches
	Excessive fatigue		Weight loss/gain		Moles that have changed
	Heartburn		Constipation		Diarrhea
	Black tarry stools		Recurrent stomach pain		Bladder control/leak
	Vaginal discharge (itching/burning)		Difficulty swallowing		Sores in the mouth
	Long-term back pain		Swollen painful joints		Swelling of feet/ankles
	Autoimmune disease		Difficulty with anesthesia		Osteoporosis
	Rheumatoid arthritis		Pulmonary embolism		HIV/AIDS
	Fibromyalgia		Gout		Irregular heartbeat

Please describe any other medical problems not listed above:

____

____

PREVIOUS HOSPITALIZATIONS: PREVIOUS SURGERIES:

Year	Reason for hospitalization	Year	Type of surgery

FAMILY MEDICAL HISTORY:

Family member	Age	Living	Major illness
Father			
Mother			
Brother(s)			
Sister(s)			

IMMEDIATE FAMILY WITH ANY OF THE FOLLOWING:

Family member(s)	Condition	Family member(s)	Condition
	Cancer		Alcoholism
	Goiters		Allergy
	Kidney disease		Bleeding tendency
	Tuberculosis		Asthma

ALLERGIES:

Type	Allergies	Reaction
Non-drug		
Drug		
Food/seafood		

MEDICATIONS: *Include all current medications and supplements*

Medication name	Dose	Frequency

PROCEDURES:

Procedure type	Month/year
Colonoscopy	
Mammogram	
PAP	
Bone density	
PSA	

IMMUNIZATIONS:

Immunization	Year
Tetanus	
Flu vaccine	
Pneumonia	
HPV	
Hepatitis B	

CHECK ALL THAT APPLY:

	Illegal drugs		Regular exercise		Special diet
	Good support group		Wear seatbelt/helmet		Alcohol use
	Caffeine consumption		Smoker		Chewing tobacco

FAMILY SHARED INFORMATION

Patient name: ____ Date of birth: ___/___/___

I herby consent that my healthcare information may be shared both verbally and by mail with the following individuals:

Name:	Relationship:
Telephone number:	

Name:	Relationship:
Telephone number:	

Name:	Relationship:
Telephone number:	

Signature: ____ Date: ___/___/___

AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

PATIENT:

______________________________	______________________________
Patient name/previous name(s)	*Date of birth*
Street address	*City, State, Zip code*

AUTHORIZES FROM:

____
Name of health care provider/plan/other

____
Street address

____
City, State, Zip code

RELEASE OF PROTECTED INFORMATION TO:

OakLeaf Clinics – Foot & Ankle

Phone: 715-834-2788
Fax: 715-834-2845

For the following dates: ___/___/___ to ___/___/___

INFORMATION TO BE RELEASED:

___ Medical history, examination, reports ___ Surgical reports ___ Immunizations

___ Treatment or tests ___ Hospital records/reports ___ Radiology reports ___ Laboratory reports

___ Consultations ___ Other: ______________________________

In compliance with Wisconsin Statutes, to release privileged information; please release records pertaining to:

___ Mental health ___ Developmental disabilities ___ Alcohol and other drug abuse

___ HIV (AIDS) ___ Sexually transmitted disease results ___ Clinical therapy (counseling) notes

___ Mental health admission/discharge summary ___ Mental health hospital assessments/notes

PURPOSE OF DISCLOSURE:

___ Further medical treatment ___ Legal investigation/action ___ Personal

___ Insurance eligibility/benefits ___ Changing physicians

___ Other: ______________________________

YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATION:

Right to Inspect or Copy the Health Information to be Used or Disclosed - I understand that I have the right to inspect or copy the health information I have authorized to be used or disclosed by this authorization form. I may arrange to inspect my health information or obtain copies of my health information by contacting Oakleaf Clinic, SC. Right to Receive Copy of this Authorization – I understand that if I agree to sign this authorization, which I am not required to do, I may be provided with a signed copy of the form. Right to Refuse to Sign This Authorization – I understand that I am under no obligation to sign this form and that the person(s) or organization(s) listed above who I am authorizing to use and/or disclose my information may not condition treatment, payment, enrollment in a health plan or eligibility for health care benefits on my decision to sign this authorization. To obtain information on how to withdraw my authorization or to receive a copy of my withdrawal, I may contact Oakleaf Clinics, SC. I am aware that my withdrawal will not be effective as to uses and/or disclosures of my health information that a person(s) and/or organization(s) listed above have already made in reference to this authorization.

Disclosure notice to recipient of mental health, alcohol and/or drug treatment records: This information has been disclosed to you from records whose confidentiality is protected by federal law. Federal regulations (42 CRF Part 2) prohibit you from making any further disclosure of it without the specific written consent of the person who is the subject of such information or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is NOT sufficient for this purpose.

EXPIRATION DATE: This authorization is good until the following date(s) ______________________ or for one year from the date signed.

I understand the content of this authorization form and confirm that it accurately reflects my wishes.

Note: A patient (18 years or older) must authorize the release of their own information unless patient is incapacitated or deceased. If signing for a minor patient, I herby state that my parental rights have not been revoked by a court of law. Specific situation(s) may require minor's authorization.

____ ___/___/___
Signature of patient or legal representative *Date*

____
Relationship (if not patient)

____ ___/___/___
Witness *Date*

Scan: Release Forms