New Patient Form
Foot & Ankle Institute of Hawaii, LLC

99-128 Aiea Heights Drive, Suite 205
Aiea, Hawaii 96701

1029 Kapahulu Avenue, Suite 307
Honolulu, Hawaii 96816

Phone 808 487-6903
Fax 808 487-6906

Date _____/_____/_____

Patient Name: _____
(First) *(MI)* *(Last)*

Social Security # _____ - _____ - _____ Date of Birth: _____

Age _____ Sex _____ Personal Physician: _____

Marital Status _____ Spouse's Name: _____

Address: _____
(Street) *(Apt #)*

_____
(City) *(State)* *(Zip)*

Home Phone # _____ Work Phone # _____

Cell Phone # _____ Email Address _____

Employer _____ Occupation _____

In Case of Emergency Notify _____ Relationship _____

Home Phone # _____ Cell Phone # _____

How did you learn about our office?

- ☐ Doctor Referral ☐ Dr. _____
- ☐ Family Member / Friend ☐ Who?
- ☐ Yellow Pages
- ☐ Newspaper
- ☐ Internet
- ☐ Other _____

INSURANCE INFORMATION

PRIMARY Insurance Co._____

Subscriber's Name _____

Birth Date _____

ID# _____

Group # _____

Secondary Insurance Co. _____

Subscriber's Name _____

Birth Date _____

ID# _____

Group # _____

Foot & Ankle Institute of Hawaii, LLC - New Patient Form, continued

What brings you to our office?

_____

_____

_____

MEDICAL HISTORY / REVIEW OF SYMPTOMS: (Circle all that apply)

Constitutional Symptoms:	Fever	Weight Loss	Nausea/Vomiting	Chills	**Other: (describe)**
Eyes:	Glasses	Contacts	Blurred Vision	Double Vision	
Head/Eyes/Ears/Nose/Throat:	Headaches	Eyes/Ear problems	Hoarseness	Sinus Infection	
Cardiovascular:	Chest Pain	High Blood Pressure	Heart Attack	Heart Disease	
	Arrhythmia	Heart Murmur	Poor Circulation	Swelling	
Respiratory:	Shortness of Breath	Asthma	Emphysema	Cough	
Gastro-Intestinal:	Decreased Appetite	Diarrhea	Constipation	Abdomen Pain	
Genito-Urinary:	Kidney Disease	Bladder Infection	Incontinence	Urgency	
Musculo-Skeletal:	Arthritis	Fractures	Gout	Joint Swelling	
Skin:	Rashes / Itching	Psoriasis	Bruise Easily	Masses/Lesions	
Neurologic:	Stroke	Seizures	Weakness	Numbness	
Psychologic:	Depression	Anxiety	Mental Disorder		
Endocrine:	Diabetes	Thyroid Problems			
Hematologic/Lymphatic:	HIV	Bleeding Disorder	Hepatitis	Cancer	
Use ambulatory aids?	Cane	Walker	Crutches	Wheelchair	
Females: Are you pregnant?	Yes	No	Post-menopausal	Breast-Feeding	Last menses:

PRIOR SURGERIES & Yr.

_____

_____

_____

_____

_____

_____

_____

MEDICATIONS ☐None

_____

_____

_____

_____

_____

_____

_____

ALLERGIES ☐None

☐Antibiotic
☐Anesthetic ☐Iodine
☐Aspirin ☐Latex
☐Codeine ☐Sulfur
☐Shellfish ☐Tape
☐Other _____
☐Reaction? _____

SOCIAL HISTORY ☐None

☐Smoking pks/day x yrs
☐Alcohol days/wk
☐Drugs ☐STD
☐Other? _____
☐Athletic Activities _____

FAMILY MEDICAL HISTORY

☐ GI Problem ☐ Diabetes ☐ Poor Circulation ☐ Heart Disease ☐ Bleeding Disorder ☐ Cancer
☐ Kidney Disease ☐ Lung Disease ☐ Gout ☐ Liver Disease ☐ Other ☐ Other

ASSIGNMENT OF INSURANCE BENEFITS:

The undersigned hereby authorizes the release of any information relating to all claims for benefits submitted on behalf of myself and/or dependents. I further expressly agree and acknowledge that my signature on this document authorizes my physician to submit claims for benefits, for services rendered or for services to be rendered, without obtaining my signature on each and every claim to be submitted for myself and/or dependents, and that I will be bound by this signature as though the undersigned had personally signed the particular claim.

I, _____ hereby authorize _____

(PRINT Name of Insured) **(Name of Insurance Company)**

I understand that honest and complete answers to each question stated above are important to the provision of my medical care and I have answered them to the best of my ability. I have been informed that if I am uncertain about any question on the form I should ask the doctor or the office staff for assistance. I hereby give permission to Dr. Avino or Dr. Hicks to administer treatment and to perform such procedures deemed necessary in the diagnosis and/or treatment of the extremity condition. I also hereby assign to the above named physicians all benefits provided by my insurance company policy or policies for medical or surgical care. I understand that I am financially responsible for any balance due on my account.

_____ _____

(Authorized signature of Subscriber or Patient) **(Date)**

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

ACKNOWLEDGEMENT OF OFFICE POLICY REGARDING MISSED APPOINTMENTS FOR

Attilio Avino Jr., DPM; FACFAS

&

Cindy L. Hicks, DPM

By signing this form, I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read if I so chose) and understood the Notice.

By signing this form, I also acknowledge that I will be charged a fee in the amount of $25 for failure to maintain a confirmed appointment or for failure to provide the office staff with notice of cancellation of an appointment at least 24 hours in advance.

_____ _____

Patient Name (please print) **Date**

_____

Parent or Authorized Representative (please print)

_____

Parent or Authorized Representative (please sign)