ADULT & PEDIATRIC FOOT CENTER, LLC

ANTONIO L. KNOWLES, D.P.M.
5362 Estate Office Park Drive, Suite 1, Memphis, TN 38119
PHONE: (901) 537-0078 FAX: (901) 537-0096

Patient Registration Form **(Please Print Clearly)** **Date:** ____________________

How did you hear about or office? ____Relative/Friend ____Internet ____Yellow Pages ____PCP ____Other

Name: ____________________ ____________________ __________ **Date of Birth:** ____________________
(Last) (First) (MI)

Address: ______________________________ **City:** ____________________ **State:** ____ **E-mail:** ______________

Zip Code: ______________ **Phone Number:** ____________________ **Social Security Number:** ______________

Sex: ____Male ____Female Marital Status: ____Married ____Single ____Divorced ____Widowed

Employer Information

Name of Employer: ______________________________ **Occupation:** ____________________

Employer Address: ______________________________ **Phone Number:** ____________________

Insurance Information

Primary Insurance: ____________________ **Secondary Insurance:** ____________________

Phone Number: ____________________ **Phone Number:** ____________________

ID Number: ____________________ **ID Number:** ____________________

Group Number: ____________________ **Group Number:** ____________________

Name of Insured: ____________________ **Name of Insured:** ____________________

Insured Date of Birth: ____________________ **Insured Date of Birth:** ____________________
Relationship to Insured: ____________________ **Relationship to Insured:** ____________________

Emergency Notification

Name of Emergency Contact: ______________________________ **Phone Number:** ____________________

Primary Care Information

Name of Primary Care Physician: ______________________________ **Phone Number:** ____________________

Assumption of Financial Responsibility

In order to obtain medical service from the physicians and staff of Dr. Antonio Knowles, the undersigned agrees as follows:
The undersigned shall be financially responsible for all medical service and supplies provided by the physician, nurses or technician of Dr. Antonio Knowles. The undersigned hereby assigns to Dr. Antonio Knowles all of the undersigned's right, title and interest in any medical proceeds payable for the treatment rendered to the patient and further agree to deliver all drafts and checks received by the undersigned from insurance companies, properly endorsed to, Dr. Antonio Knowles. Dr. Antonio Knowles is hereby authorized and requested to furnish to any insurance company, other third party payer, hospital or physician and any and all information it may have concerning the patient named above including, but not limited to, medical history, reports, consultation, prescriptions, treatment, including x-rays, and any and all other requested information and/or documentation pertaining to such patient. A photostatic copy of this authorization shall be considered as valid and effective as the original. If more than one person signs below, each is jointly and severally liable with the other. The undersigned execute this agreement for the purpose of inducing Dr. Antonio Knowles, to provide medical service and supplies to the patient named above. This authorization includes the release of information to Dr. Antonio Knowles.

______________________________ ____________________

Patient/Responsible Party Signature **Date**

ADULT & PEDIATRIC FOOT CENTER, LLC
ANTONIO L. KNOWLES, D.P.M.
5362 ESTATE OFFICE PARK DRIVE, STE. 1
MEMPHIS, TN. 38119
PHONE: (901) 537-0078 FAX: (901) 537-0096

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

* Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
* Obtain payment from third-party payers.
* Conduct normal healthcare operations such as quality assessments and physician certifications.

I acknowledge that I have received your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Privacy Practices.*

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

____
Patient/Responsible Party Print

_______________________________ ____________
Patient/Responsible Party Signature **Date**

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Record ID # 832030

DOCUFORMS™ POD-2010
Confidential Office Medical Record

☐ Only Changes To The Previous History Information Are Noted

1 PATIENT IDENTIFICATION AND CONTACT INFORMATION

Patient Acct #

First Name: | MI: | Last Name: | Your type of Job Activity / Occupation: | ☐ I prefer to be addressed as: Mr. Mrs. Miss Ms. Dr.

Last 4 digits of Socal Sec. #: | Sex M / F | Age | Birth Date: / / | Shoe Size: | Weight: | Height: | ☐ I prefer to be addressed by: ○ First Name ○ Nick Name:

Phone Numbers For Contacting You:
Day: ( ) -
Evening: ( ) -
Cell/Pager: ( ) -

In Case of Emergency, Please Call:
Day: ( ) -
Evening: ( ) -

Please Provide Your Preferred Pharmacy:
Street / City:
Day: ( ) -

☐ INITIAL HISTORY

2 COMPREHENSIVE PATIENT MEDICAL HISTORY

ROS/PFSH

Have you had/been treated for:
☐ Warts ☐ Athlete's Foot
☐ Corns/Calluses ☐ Fungal Nails ☐ Ingrown nails
☐ Leg or Foot Ulcers ☐ Neuroma ☐ Foot Numbness
☐ Broken foot bone(s) ☐ Broken Ankle ☐ Ankle sprain
☐ Hammer/Mallet toes ☐ Bunions ☐ Flat feet
☐ Cramps in legs/feet ☐ Arch pain ☐ High arch feet
☐ Lower back pain ☐ Knee pain ☐ Heel pain
☐ Gait (Walking) problems ☐ In-toeing ☐ Toe walking
☐ **Childhood foot problems** ☐ Rash ☐ ***NONE of these***

Did you previously or do you now wear:
Shoe inserts? Y N Still using them? Y N Do or did they help? Y N
Orthotics? Y N Still using them? Y N Do or did they help? Y N
The orthotics were obtained from: ○ Another Podiatrist ○ An Orthopedist ○ A Physical Therapist ○ A Chiropractor ○ Other:

Are your first steps out of bed painful? Y N **... then subsides?** Y N
Do you get leg cramps ...during the Day? Y N **...at Night?** Y N
Percent of waking hours spent on your feet? 20% 40% 60% 80% 100%

List the sports/type of dance your are active in:

Does foot pain limit your desired activities? ☐ Yes ☐ No
Do you have any difficulty in walking? ☐ Yes ☐ No
Any pain in calves or buttocks when walking? ☐ Yes ☐ No
Is the pain relieved by stopping & standing still? ☐ Yes ☐ No

Do you have or have you ever been treated for:
☐ Stroke ☐ Heart Attack ☐ High Blood Pressure
☐ Phlebitis ☐ Vascular Disease ☐ A Heart Condition
☐ Anemia ☐ Poor Circulation ☐ Eyes:Glaucoma/Manicular Deg.
☐ Diabetes ☐ Kidney Disease ☐ Keloid/Thick Scar
☐ Gout ☐ Osteoporosis ☐ Alzheimer's
☐ Sciatica ☐ Lyme's Disease ☐ Rheumatic Fever
☐ Arthritis ☐ Headaches ☐ Hearing/Ear Disorder
☐ Epilepsy ☐ Nerve Disorder ☐ Psychiatric Disorder
☐ Asthma ☐ Lung Disease ☐ Tuberculosis
☐ Hepatitis ☐ Liver Disease ☐ Thyroid Problem
☐ Dark Urine ☐ Chronic Light Stool ☐ Unexplained Weight Loss
☐ Cancer ☐ Stomach Ulcer ☐ ***NONE of these***
☐ Other(s):

Do you have vascular grafts? *(If yes, explain below)* ☐ Yes ☐ No
Do you have joint implants? *(If yes, explain below)* ☐ Yes ☐ No
Do you have replacement heart valves? ☐ Yes ☐ No
Are you now under active chemotherapy? ☐ Yes ☐ No
Have you had any other serious illness? *(List below)* ☐ Yes ☐ No
Have you had any surgery? *(If yes, explain below)* ☐ Yes ☐ No
Have you ever been hospitalized or been under medical care over 24 hrs? *(If yes, explain below)* ☐ Yes ☐ No

I Had Surgery for: on date of: w/ complications of:

List relationship to you of family members who have had:
Diabetes ____ Foot Problems ____
Arthritis ____ Heart Attack ____
Stroke ____ High Blood Pressure ____
Cancer ____ Birth Defects ____

# of childbirths ___ Are you currently pregnant? ☐ Yes ☐ No
Are you slow to heal after cuts? ☐ Yes ☐ No
Any abnormal bruising, bleeding or scarring? ☐ Yes ☐ No
Do you smoke now? ☐ No ☐ Yes Packs/day ___ Years___
Did you ever smoke? ☐ No ☐ Yes Packs/day ___ Years___
If you quit, when did you do so?
Alcoholic beverages? *(Circle one)* None Rarely Moderately Daily Quit
Recreational Drugs? *(Circle one)* None Rarely Moderately Daily Quit
Please mark if you take vitamins or supplements that contain ○ *garlic,* ○ *Gingko biloba,* ○ *echinacea,* ○ *ginseng or* ○ *St. John's Wort*
Are you currently taking any medications? List below! ☐ Yes ☐ No
Are you taking Insulin? If yes, list below. ☐ Yes ☐ No

When noting frequency: A = As needed, x/ = times per D = day, W = week,

List: Medications	Dose?	How Often?	For Treatment of?
		A, __x/ D W,	
		A, __x/ D W,	
		A, __x/ D W,	
		A, __x/ D W,	
		A, __x/ D W,	

Are you taking your medications as prescribed? ☐ Yes ☐ No

Allergies: Is there a history of skin reaction or other outward reaction or sickness following an injection, oral or topical administration of:

(Check the answer box that applies)	No	Yes	*If yes, what happens?*
Latex, Adhesive tape *(circle)*	☐	☐	
Penicillin	☐	☐	
Other antibiotics *(list below)*	☐	☐	
Empirin, Tylenol *(if yes, circle)*	☐	☐	
Aspirin, Advil, Aleve, or Motrin *(circle)*	☐	☐	
Celebrex	☐	☐	
Other pain remedies *(list below)*	☐	☐	
Morphine	☐	☐	
Codeine	☐	☐	
Demerol	☐	☐	
Other narcotics *(list below)*	☐	☐	
Novocaine	☐	☐	
Other anesthetics *(list below)*	☐	☐	
Sulfa drugs	☐	☐	
Shrimp, Iodine, or Merthiolate	☐	☐	
Any other drugs or medications	☐	☐	

Others:

Anything else that you want to tell the doctor? ☐ Yes ☐ No
Illnesses/Explanations:

☐ UPDATE OF HISTORY TAKEN

PATIENT HISTORY AS OF / /

PLEASE CONTINUE ON THE OTHER SIDE TO PROVIDE ADDITIONAL DETAILS.

Patient CC# (s)

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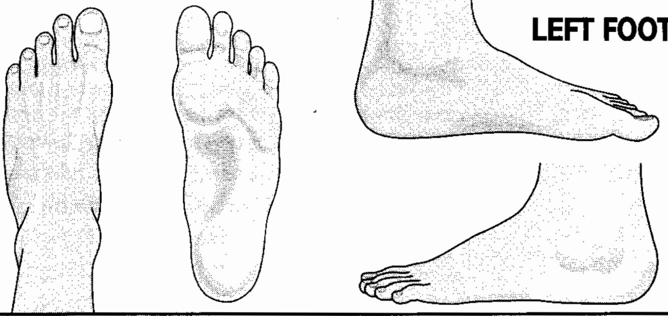
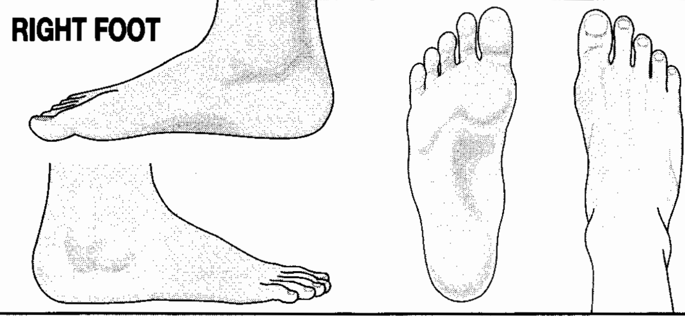
3 PATIENT'S CURRENT CHIEF COMPLAINTS CC/HPI

Describe 1 or 2 main problems in greater detail below & mark on the diagrams below the areas where you have each problem using numbers 1 & 2 to identify them.





❶ Please mark the location of your first problem or pain on the diagrams above with a number **1**. Describe your problem below and its cause if you know. Please describe associated pain to the right ➡

My first problem is ... ☐ On Left foot ☐ On Right foot ☐ On Both feet.

It causes me difficulty: ☐ walking, ☐ wearing shoes, and/or it ...

____

______________________ Is problem work related? [Y] [N]

Date of injury: / / Date of report to employer: / /

PAIN: Please indicate the severity of your pain or discomfort: [0] None.... [1] Light ... [2] Moderate ... [3] Strong ... [4] Severe

My Pain/Discomfort is:
☐ Shooting Pain
☐ Throbbing Pain
☐ Sharp Pain
☐ Burning Pain
☐ Itching
☐ Aching Pain
☐ Tenderness
☐ Dull Pain
☐ Tingling
☐ Numbness

How long ago did the problem (pain) start?:
_____ ○ days, ○ weeks, ○ months, ○ years ago

The pain from my problem occurs:
☐ while walking and/or ☐ while not walking
☐ and/or: ______________________

Previous medical treatment(s) or home remedies:
____

❷ Please mark the location of your second problem or pain on the diagrams above with a number **2**. Describe your problem below and its cause if you know. Please describe associated pain to the right ➡

My second problem is ... ☐ On Left foot ☐ On Right foot ☐ On Both feet.

It causes me difficulty: ☐ walking, ☐ wearing shoes, and/or it ...

____

______________________ Is problem work related? [Y] [N]

Date of injury: / / Date of report to employer: / /

PAIN: Please indicate the severity of your pain or discomfort: [0] None.... [1] Light ... [2] Moderate ... [3] Strong ... [4] Severe

My Pain/Discomfort is:
☐ Shooting Pain
☐ Throbbing Pain
☐ Sharp Pain
☐ Burning Pain
☐ Itching
☐ Aching Pain
☐ Tenderness
☐ Dull Pain
☐ Tingling
☐ Numbness

How long ago did the problem (pain) start?:
_____ ○ days, ○ weeks, ○ months, ○ years ago

The pain from my problem occurs:
☐ while walking and/or ☐ while not walking
☐ and/or: ______________________

Previous medical treatment(s) or home remedies:
____

4 PATIENT'S DOCTORS - PLEASE TELL US WHOM TO THANK AND WITH WHOM TO COORDINATE YOUR CARE

My:	Physician's Name:	Phone Number	City	Date Last Seen	Referred me:	I was sent or came in especially for:
Family/ Primary				__/__/__	[Y] [N]	2nd Opinion / Surgcl Eval / Consult
Specialist				__/__/__	[Y] [N]	2nd Opinion / Surgcl Eval / Consult
Other Podiatrist				__/__/__	[Y] [N]	2nd Opinion / Surgcl Eval / Consult

5 FOR DOCTOR'S USE - OBSERVATIONS & COMMENTS

☐ Patient was ○ assisted in completion of this record by or was ○ unable to complete without the help of: ______________.

☐ Translation was done by ______________ in ○ Spanish, ○ ______________.

☐ Additional Information† obtained from ○ Family/Care givers and/or ○ Physician(s) ______________

☐ Lab Reports† and/or ☐ Previous Medical Records† were reviewed. ☐ X-rays† brought by patient from ______________ were reviewed.

† Elaborations: ______________________________

I have reviewed the information provided above ______________. ☐ My annotations to patient's entries are marked in: ______ (INK COLOR)

Doctor's Signature X ______________ Date __/__/__ MP ☐ See Additional Documentation

Record ID # 832030

Confidential Office Medical Record

☐ QA Review by ______ on __/__/__

☐ Only Changes To The Previous History Information Are Noted

PATIENT HISTORY __/__/__

Patient Name Last, First, Middle

Medical Record # or Last 4 Digits of SSN

Sex Age DOB __/__/__

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Elements of HPI (History of Present Illness): • Location • Severity • Context • Quality • Duration • Modifying Factors • Associated Signs & Symptoms