HOSPITAL FOR SPECIAL SURGERY

Foot and Ankle Service
Patient Registration Form – Part 1

Date: ☐☐☐☐☐☐ MRN #: ☐☐☐☐☐☐☐☐

Physician: ◯ Dr. Bohne ◯ Dr. Deland ◯ Dr. Elliott ◯ Dr. Ellis ◯ Dr. Kennedy
◯ Dr. Levine ◯ Dr O'Malley ◯ Dr. Roberts ◯ Dr. Drakos ◯ Dr. Demetracopoulos

Please complete this form in its entirety. If you have previously completed this form, fill in your name, today's date, provide us with any changes that have occurred since your last visit and sign the last page of this form.

VISIT: ◯ Initial Visit ◯ Follow Up ◯ Pre-Op Visit ◯ Post-Op ◯ Study Patient

Last Name:	First Name:	M.I.:

Street Address / PO Box / Apartment Number: _____

City: State: Zip: Country:

Temporary Address in the US: Birthplace:

Home Phone Number: _____

Day Phone Number: _____

Cell/Alternative Phone Number: _____

E-mail: _____

DATE OF BIRTH: Month ☐☐ - Day ☐☐ - Year ☐☐

GENDER: Male ◯ Female ◯

Social Security Number: ☐☐☐ - ☐☐ - ☐☐☐☐

Emergency contact Name & Relationship & Phone Number: _____

Phone Number:

Guarantor Responsible for the bill & Phone Number: _____

Spouse Name & Employment Information:

Race (Optional): ◯ White ◯ Black ◯ Hispanic Origin ◯ Asian / Pacific Islander ◯ Other

Occupation: _____ Employer/Address: _____

◯ *Full Time* ◯ *Part Time* ◯ *Self Employed* ◯ *Between Jobs* ◯ *Retired*

Marital Status: ◯ Single ◯ Married ◯ Divorced ◯ Separated ◯ Widowed ◯ Domestic Partner

Do you Live Alone? ◯ Yes ◯ No If No, how many people do you live with? ◯ 1 ◯ 2 ◯ 3 ◯ More

Primary Insurance:	Group/Policy #:	Secondary Insurance:	Group/Policy #:
Address:		Address:	
Insured's Name:		Insured's Name:	
Insured's Date of Birth: / /		Insured's Date of Birth: / /	
Relation to Patient:		Relation to Patient:	

Accident / Injury: ◯ Yes ◯ No Date/Time of Injury: ___/___/____, ____:____ Place of Injury: _____

Receiving worker's compensation ◯ Yes ◯ No

WCB Case #:	Claim #:	No Fault #:
Carrier:	Address:	Contact:

HOSPITAL FOR SPECIAL SURGERY

Foot and Ankle Service

Patient Registration Form – Part 2a

Date: ☐☐/☐☐/☐☐ MRN #: ☐☐☐☐☐☐☐☐

Patient First Name: _____ **Last Name:** _____ **Age:** _____ **Occupation:** _____

Primary Care Physician: Physician's Address & Phone:	Referred by: Referred Address & Phone:	Orthotics: ◯ Yes ◯ No
Prior Surgery & Date (Please list them): 1. _____ 2. _____ 3. _____	Complications from Prior Surgery: ◯ Yes ◯ No If Yes, please explain: _____ _____	Have you ever had general anesthesia? ◯ Yes ◯ No Have you ever had any problems with anesthesia? ◯ Yes ◯ No

Reason for Today's Visit: _____

Duration Symptoms: ◯ Less than 1 month ◯ 1-6 Months ◯ 1-3 Years ◯ 5 or more Years

Site: ◯ Right ◯ Left ◯ Both Location of Pain: ◯ Foot ◯ Ankle ◯ Both ◯ Toe/s ◯ Other

Have you been treated for this problem before? ◯ No ◯ Yes If Yes, when? ___/___/___ where: _____

Previous patient at Hospital for Special Surgery: ◯ Yes ◯ No If Yes, ◯ Foot ◯ Ankle

or ◯ Other (Specify): _____

Name and address of physician/s: _____

Accident / Injury: ◯ Yes ◯ No Date of Injury: ___/___/____ During Sport ◯ Yes ◯ No

At Work: ◯ Yes ◯ No At Home: ◯ Yes ◯ No ◯ Other Explain: _____

Do you smoke? ◯ Yes ◯ No

If Yes, packs a day ☐ for ☐ years

Quit ☐ years ago

Do you drink alcohol? ◯ Yes ◯ No

If Yes, ◯ Daily ◯ Weekly ◯ Monthly

Are you a Vegetarian? ◯ Yes ◯ No

Are you on Hormone Replacement Therapy? ◯ Yes ◯ No

Athletic and Physical Activities:

◯ Biking ◯ Walking ◯ Running ◯ Football ◯ Tennis ◯ Basketball ◯ Soccer

◯ Hockey ◯ Lacrosse ◯ Swimming ◯ Weight Lifting ◯ Golf ◯ Squash ◯ Dancing / Aerobics

Level of Play: ◯ Professional ◯ College ◯ High School ◯ Recreational

HOSPITAL FOR SPECIAL SURGERY

Foot and Ankle Service
Patient Registration Form – Part 2b

Date: ☐☐☐☐☐☐ MRN #: ☐☐☐☐☐☐☐☐

Please fill out any illness you and your family have or had:

	Own	Family		Own	Family		Own	Family
Bleeding tendency	◯	◯	Kidney Disease	◯	◯	Depression	◯	◯
Rheumatic fever	◯	◯	Blood in urine	◯	◯	Anxiety	◯	◯
High blood pressure	◯	◯	Bladder infections	◯	◯	Arthritis	◯	◯
Heart attack	◯	◯	Difficulty controlling urine	◯	◯	Osteoarthritis	◯	◯
Chest pain	◯	◯	Glaucoma	◯	◯	Osteoporosis	◯	◯
Heart palpitations	◯	◯	Lupus Erythematosis	◯	◯	Rheumatoid Arthritis	◯	◯
Chronic Pulmonary Disease	◯	◯	Fatigue	◯	◯	Gout	◯	◯
Shortness of breath	◯	◯	Seizures	◯	◯	Sciatica	◯	◯
Pneumonia	◯	◯	Dizziness/fainting	◯	◯	Phlebitis	◯	◯
Asthma	◯	◯	Headache	◯	◯	Varicose veins	◯	◯
Tuberculosis	◯	◯	Stroke/TIA	◯	◯	Anemia	◯	◯
Ulcers	◯	◯	Weakness	◯	◯	Shingles	◯	◯
Colitis	◯	◯	Numbness	◯	◯	Blood Clot	◯	◯
Diverticulitis	◯	◯	Cancer	◯	◯	Venereal disease	◯	◯
Diabetes	◯	◯	Sleep Apnea	◯	◯	Hepatitis	◯	◯
Liver Disease	◯	◯	Thyroid disease	◯	◯		Own	Family

Other (specify) _____ ◯ ◯

Other (specify) _____ ◯ ◯

Other (specify) _____ ◯ ◯

List of current medication: **Dosage:**

1. _____ _____
2. _____ _____
3. _____ _____

Allergies: ◯ Yes (please list below) ◯ No

1. _____
2. _____
3. _____

Assignment and Release of Information statement: I certify that the information provided by me is correct. I understand that this information is entered into a database, and I hereby authorize the sharing of such information with Hospital- affiliated physicians who are responsible for my care and their offices. I hereby also authorize the release of information related to my medical care as requested by government agencies and/or insurance carriers. I hereby assign benefits to the physician and understand that in the absence of accepted insurance coverage, I/legal guardian am responsible for full payment of services rendered.

Medicare patients: I certify that the information giving by me in applying for payment under Title XVII of the Social Security Act is correct.
I understand that I am responsible for insurance deductibles and co-insurance payments on all services. When Medicare is deemed the secondary insurance, I will follow payment terms.

Patient/Guardian Name: _____ **Signature:** _____ **Date:** _____

Physician Name: _____ **Signature:** _____ **Date:** _____

HOSPITAL FOR SPECIAL SURGERY

Foot and Ankle Service

Foot & Ankle Survey

Date: ☐☐☐☐☐☐ MRN #: ☐☐☐☐☐☐☐☐

Patient First Name: _____ Last Name: _____

Physician:

○ Dr. Bohne ○ Dr. Deland ○ Dr. Elliott ○ Dr. Ellis ○ Dr. Kennedy

○ Dr. Levine ○ Dr. O'Malley ○ Dr. Roberts ○ Dr. Drakos ○ Dr. Demetracopoulos

INSTRUCTIONS: This survey asks for your level of activity. This information will help us keep track of how your symptoms interfere with your functioning.
Please answer every question by filling in the appropriate circle, only one selection for each question. If you are unsure about how to answer a question, please give the best answer you can.

Symptoms

These questions should be answered thinking of your foot/ankle symptoms during the last week.

	Never	Rarely	Sometimes	Often	Always
S1. Do you have swelling in your foot/ankle?	○	○	○	○	○
S2. Do you feel grinding? Hear clicking or any other type of noise when your foot/ankle moves?	○	○	○	○	○
S3. Does your foot/ankle catch or hang up when moving?	○	○	○	○	○

	Always	Often	Sometimes	Rarely	Never
S4. Can you straighten your foot/ankle fully?	○	○	○	○	○
S5. Can you bend your foot/ankle fully?	○	○	○	○	○

Stiffness

The following questions concern the amount of joint stiffness you have experienced during the last week in your foot/ankle. Stiffness is a sensation of restriction or slowness in the ease with which you move your joints.

	None	Mild	Moderate	Severe	Extreme
S6. How severe is your foot/ankle stiffness after first wakening in the morning?	○	○	○	○	○
S7. How severe is your foot/ankle stiffness after sitting, laying or resting later in the day?	○	○	○	○	○

Pain

	Never	Monthly	Weekly	Daily	Always
P1. How often do you experience foot/ankle pain?	○	○	○	○	○

What amount of foot/ankle pain have you experienced the last week during the following activities?

	None	Mild	Moderate	Severe	Extreme
P2. Twisting/pivoting on your foot/ankle	○	○	○	○	○
P3. Straightening foot/ankle full	○	○	○	○	○
P4. Bending foot/ankle fully	○	○	○	○	○
P5. Walking on flat surface	○	○	○	○	○
P6. Going up or down stairs	○	○	○	○	○
P7. At night while in bed	○	○	○	○	○
P8. Sitting or laying	○	○	○	○	○
P9. Standing upright	○	○	○	○	○

Function, daily living

The following questions concern your physical function. By this we mean your ability to move around and to look after yourself. For each of the following activities please indicate the degree of difficulty you have experienced in the last week due to your foot/ankle.

	None	Mild	Moderate	Severe	Extreme
AI. Descending stairs	○	○	○	○	○
A2. Ascending stairs	○	○	○	○	○
A3. Rising from sitting	○	○	○	○	○
A4. Standing	○	○	○	○	○
A5. Bending to floor/pick up an object	○	○	○	○	○
A6. Walking on flat surface	○	○	○	○	○
A7. Getting in/out of car	○	○	○	○	○
A8. Going shopping	○	○	○	○	○
A9. Putting on socks/stockings	○	○	○	○	○
A10. Rising from bed	○	○	○	○	○

	None	Mild	Moderate	Severe	Extreme
A11. Taking off socks/stockings	○	○	○	○	○
A12. Lying in bed (Turning over, maintaining knee position)	○	○	○	○	○
A13. Getting in/out of bath	○	○	○	○	○
A14. Sitting	○	○	○	○	○
A15. Getting on/off toilet	○	○	○	○	○
A16. Heavy domestic duties (moving heavy boxes, scrubbing floors, etc.)	○	○	○	○	○
A17. Light domestic duties (cooking, dusting, etc.)	○	○	○	○	○

Function, sports and recreational activities

The following questions concern your physical function when being active on a higher level.
The questions should be answered thinking of what degree of difficulty you have experienced during the last week due to your foot/ankle.

	None	Mild	Moderate	Severe	Extreme
SP1. Squatting	○	○	○	○	○
SP2. Running	○	○	○	○	○
SP3. Jumping	○	○	○	○	○
SP4. Twisting/pivoting on your injured foot/ankle	○	○	○	○	○
SP5. Kneeling	○	○	○	○	○

Quality of Life

	Never	Monthly	Weekly	Daily	Constantly
Q1. How often are you aware of your foot/ankle problem?	○	○	○	○	○
	Not at all	Mildly	Moderately	Severely	Totally
Q2. Have you modified your life style to avoid potentially damaging activities to your foot/ankle?	○	○	○	○	○
	Not at all	Mildly	Moderately	Severely	Extremely
Q3. How much are you troubled with lack of confidence in your foot/ankle?	○	○	○	○	○
	None	Mild	Moderate	Severe	Extreme
Q4. In general, how much difficulty do you have with your foot/ankle?	○	○	○	○	○

HOSPITAL FOR SPECIAL SURGERY

Foot and Ankle Service
General Health Survey/SF-12v2

Date: ☐☐☐☐☐☐ MRN #: ☐☐☐☐☐☐☐☐

Patient First Name:_____ Last Name:_____

This survey asks for your views about your health. This information will help keep track of how you feel and how well you are able to do your usual activities. ***Thank you for completing this survey!***

Please answer these questions taking into account all medical conditions you may have, including your foot & ankle problem. Please fill in ONLY ONE response that best describes your answer.

Physician: ○ Dr. Bohne ○ Dr. Deland ○ Dr. Elliott ○ Dr. Ellis ○ Dr. Kennedy ○ Dr. Levine ○ Dr. O'Malley ○ Dr. Roberts ○ Dr. Drakos ○ Dr. Demetracopoulos

	Excellent	Very good	Good	Fair	Poor
1. In general, would you say your health is:	○	○	○	○	○

2. The following items are about activities you might do during a typical day. Does your health now limit you in these activities? If so, how much?	Limited a lot	Limited a little	Not limited at all
a. First, moderate activities such as moving a table, pushing a vacuum cleaner, bowling or playing golf.	○	○	○
b. Climbing several flights of stairs.	○	○	○

3. During the past 4 weeks, how much of the time have you had any of the following problems with your work or other regular daily activities as a result of your physical health?	All of the time	Most of the time	Some of the time	A little of the time	None of the time
a. Accomplished less than you would like	○	○	○	○	○
b. Were limited in the kind of work or other activities	○	○	○	○	○

4. During the past 4 weeks, how much of the time have you had any of the following problems with your work or other regular daily activities as a result of any emotional problems (such as feeling depressed or anxious)?	All of the time	Most of the time	Some of the time	A little of the time	None of the time
a. Accomplished less than you would like	○	○	○	○	○
b. Did work or other activities less carefully than usual	○	○	○	○	○

5. During the past 4 weeks, how much did pain interfere with your normal work (including both work outside the home and housework)?	Not at all	A little bit	Moderately	Quite a bit	Extremely
	○	○	○	○	○

6. These questions are about how you feel and how things have been with you during the past 4 weeks. For each question, please give the ONE ANSWER that comes closest to the way you have been feeling. How much of the time during the past 4 weeks...	All of the time	Most of the time	Some of the time	A little of the time	None of the time
a. Have you felt calm and peaceful?	○	○	○	○	○
b. Did you have a lot of energy?	○	○	○	○	○
c. Have you felt downhearted and depressed?	○	○	○	○	○

7. During the past 4 weeks, how much of the time has your physical health or emotional problems interfered with your social activities (like visiting friends, relatives, etc.)?	All of the time	Most of the time	Some of the time	A little of the time	None of the time
	○	○	○	○	○

On a scale of 0 – 10, 10 being the worst pain and 0 being no pain, how would you rate your pain?	0	1	2	3	4	5	6	7	8	9	10
	○	○	○	○	○	○	○	○	○	○	○

HOSPITAL FOR SPECIAL SURGERY

Foot and Ankle Service

Activity Rating Scale

Date: ☐☐☐☐☐☐ MRN #: ☐☐☐☐☐☐☐☐

Patient First Name: _____ **Last Name:** _____

Physician:

- ○ Dr. Bohne
- ○ Dr. Deland
- ○ Dr. Elliott
- ○ Dr. Ellis
- ○ Dr. Kennedy
- ○ Dr. Levine
- ○ Dr. O'Malley
- ○ Dr. Roberts
- ○ Dr. Drakos
- ○ Dr. Demetracopoulos

Activities:

Please, indicate how often you performed each activity in your healthiest and most active state, during the past year.

INSTRUCTIONS: This survey asks for your level of activity. This information will help us keep track of how your symptoms interfere with your functioning.

Please answer every question by filling in the appropriate circle, only one selection for each question. If you are unsure about how to answer a question, please give the best answer you can.

	Less than one time in a month	One time in a month	One time in a week	2 or 3 times in a week	4 or more times in a week
A1. Running: Running while playing a sport or jogging	○	○	○	○	○
A2. Cutting: Changing directions while running	○	○	○	○	○
A3. Decelerating: Coming to a quick stop while running	○	○	○	○	○
A4. Pivoting: Turning your body with your foot planted For example: skiing, skating, kicking, throwing, hitting a ball (golf, squash, tennis), etc.	○	○	○	○	○

Foot and Ankle Orthopaedic Surgery, P.C.
420 East 72nd Street New York, NY 10021

212-203-0740
Fax 212-203-0743

Martin J. O'Malley, MD
Andrew J. Elliott, MD
Donna J. Astion, MD

PRESCRIPTION DRUG CONSENT FORM

"I agree that Foot & Ankle Orthopaedic Surgery, PC may request and use my prescription medication history from other healthcare providers or third-party pharmacy benefit payors for treatment purposes."

Patient's Name _____

Date:

Foot and Ankle Orthopaedic Surgery, PC
420 East 72nd Street
New York, NY 10021

tel 212.203.0740
fax 212.203.0743

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Assistant Professor of Orthopaedics
Hospital for Special Surgery
Weill Medical College of Cornell University

Donna Astion, M.D. MPH
Specializing in Conservative
treatment of the foot and ankle

- I understand that payment of charges incurred is due at the time of service unless other definite financial arrangements have been made prior to treatment. In the case of surgical procedures, it is agreed and understood that, should my insurance company reimburse me for any portion of the procedure, any and all monies will be forwarded directly to the provider's office and that I am responsible for any remaining balance.

- I understand that, should my account become delinquent, it will be sent to collections and I will be responsible for any collection and attorney fees that will be incurred.

- I authorize the release of all medical records to my referring and family physician and my insurance company, if applicable.

- I allow fax transmittal of my medical records if necessary.

- It is understood that my purpose in requesting examination and treatment is medical and not in connection with pending or proposed litigation. Should such litigation arise, it is further understood that the treating physician will not participate in any way in litigation except to provide a true and accurate copy of any medical records in the possession and control of this office pursuant to an authorization by the undersigned.

Patient Name (PRINT) _____

Patient Signature _____ Date _____