PATIENT INFORMATION

DATE

PATIENT

ADDRESS

CITY/STATE/ZIP

BIRTHDATE AGE

SEX Female Male

PATIENT SSN

HOME PHONE ( )

CELL PHONE ( )

WORK PHONE ( )

EMPLOYER/OCCUPATION

MARITAL STATUS

Single Married Divorced Widowed

SPOUSE'S NAME

SPOUSE SSN

SPOUSE EMPLOYER/PHONE ( )

EMERGENCY CONTACT

NAME

RELATIONSHIP

HOME PHONE ( )

WORK PHONE ( )

WHOM MAY WE THANK FOR REFERRING YOU?

MEDICAL HISTORY

FAMILY PHYSICIAN

DATE OF LAST VISIT

ARE YOU NOW, OR HAVE YOU BEEN UNDER ANY DOCTOR'S CARE OR SURGERIES IN THE PAST TWO YEARS?

IF YES, PLEASE EXPLAIN

PODIATRIC HISTORY

WHAT IS THE CHIEF COMPLAINT FOR WHICH YOU CAME TO BE TREATED? PLEASE BE SPECIFIC.

HAVE YOU EVER BEEN TO A PODIATRIST BEFORE?

NAME?

DATE OF LAST VISIT?

DO YOU HAVE DIABETES?

IS THERE A FAMILY HISTORY OF DIABETES?

CIGARETTE/TOBACCO USE YEARS

TESTED POSITIVE FOR HIV OR HEPATITIS?

ATHLETIC ACTIVITIES IN WHICH YOU PARTICIPATE

ALLERGIES-CHECK ANY THAT APPLY

LATEX	LOCAL ANESTHETICS
ANTICOAGULANT	NOVOCAINE
ASPIRIN	PENICILLIN
CODEINE	SEAFOODS
DEMEROL	SULFA
IODINE	
OTHER	

MEDICATIONS

INCLUDE PRESCRIPTIONS, OVER-THE-COUNTER, AND VITAMINS:

PHARMACY NAME

PHARMACY NUMBER

CONSENT

I CERTIFY THAT THE ABOVE INFORMATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE. I GIVE MY PERMISSION TO THE DOCTOR TO ADMINISTER AND PERFORM SUCH PROCEDURES AS MAY BE DEEMED NECESSARY IN THE DIAGNOSIS AND/OR TREATMENT OF MY FEET. I HEREBY GIVE PERMISSION TO THE DOCTOR TO RELEASE ANY INFORMATION REQUESTED BY MY INSURANCE COMPANY ACQUIRED IN THE COURSE OF MY EXAMINATION AND TREATMENT. I AM FINANCIALLY RESPONSIBLE FOR ANY NONCOVERED SERVICES MY INSURANCE CARRIER OR MEDICARE DOES NOT COVER.
I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO THE UNDERSIGNED PHYSICIAN OR SUPPLIER FOR SERVICES DESCRIBED BELOW.

SIGNED DATE

SIGN FRONT AND BACK

SUMMARY OF NOTICE OF PRIVACY PRACTICES

This summary is provided to assist you in understanding the attached Notice of Privacy Practices

This Notice of Privacy Practices contains a detailed description of how our office will protect you patient and our common practices in dealing with patient health information. Please refer to that Notice for further information.

Uses and Disclosures of Health Information. We will use and disclose your health information in order to treat you or to assist other health care providers in treating you. We will also use and disclose your health information in order to obtain payment for our services or to allow insurance companies to process insurance claims for services rendered to you by us or other health care providers. Finally, we may disclose your health information for certain limited operational activities such as quality assessment, licensing, accreditation and training of students.

Use and Disclosure Based on Your Authorization. Except as stated in more detail in the Notice of Privacy Practices, we will not use or disclose your health information without your written authorization.

Uses and Disclosures Not Requiring Your Authorization. In the following circumstances, we many disclose your health information without your written authorization.

- To family members or close friends who are involved in your health care
- For certain limited research purposes
- For purposes of public health and safety
- To Government agencies for purposes of their audits, investigations and other oversight activities
- To government authorities to prevent child abuse or domestic violence
- To the FDA to report product defects or incidents
- To law enforcement authorities to protect public safety or to assist in apprehending criminal offenders
- When required by court orders, search warrants, subpoenas and as otherwise required by the law

Patient Rights. As our patient you have the following rights:

- To have access to and/or a copy of you health information
- To receive an accounting of certain disclosures we have made of your health information
- To request restrictions as to how your health information is used or disclosed
- To request that we communicate with our in confidence
- To request that we amend your health information
- To receive notice of our privacy practices

If you have a question, concern or complaint regarding our privacy practices, please refer to the attached Notice of Privacy Practices for the person or persons whom you may contact.

ACKNOWLEDGE OF RECEIPT of NOTICE OF PRIVACY PRACTICES

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.

Print Patients Name ________________________ **Date**________________

Parent or Authorized Representative (if applicable) ________________________

Signature ____