



Welcome to our office!

Last name: _____ First name: _____ Gender: ___M ___F

Date of birth: _____ Age: _____ Social Security #: _____ - _____ - _____

Address: _____ City _____ State _____ Zip _____

Cell phone: _____ Home phone: _____ Work phone: _____

Email address: _____

Preferred method of contact: ___Cell phone ___Home phone ___Email

Marital status: ___Single ___Married ___Divorced ___Widowed ___Legally Separated

Emergency contact: _____ Phone: _____ Relationship: _____

Employment status: ___Full-time ___Part-time ___Not employed Occupation: _____

Preferred pharmacy: _____ Phone: _____

Reason for visit: _____ Family Doctor: _____

How did you first learn about us? ___Internet search ___Our website ___TV commercial ___Newspaper ad

___Magazine ad ___Billboard ___Facebook ___Instagram ___Referred by dr. ___Referred by friend/family

___Email ___Event/expo ___Other: _____

PERSONAL MEDICAL HISTORY

Please check those that apply to you *now* or *have applied to you in the past*:

Arthritis	No	Yes	Gastritis	No	Yes
Blood transfusion (year: _____)	No	Yes	Kidney disease	No	Yes
Cancer	No	Yes	Liver disorder	No	Yes
Diabetes	No	Yes	Psychiatric problem	No	Yes
Epilepsy / seizure disorder	No	Yes	Respiratory disease / lung disease	No	Yes
GI disease (ulcers)	No	Yes	Stroke	No	Yes
Heart Disease	No	Yes	Thyroid disease	No	Yes
Hepatitis	No	Yes	Vascular disease / circulatory problems	No	Yes
Hypertension (high blood pressure)	No	Yes	Hypercholesterolemia	No	Yes
HIV or other immune deficiency	No	Yes	Asthma	No	Yes

MEDICATIONS

Please list *all* of your *current* medications:

- | | |
|----------|-----------|
| 1. _____ | 6. _____ |
| 2. _____ | 7. _____ |
| 3. _____ | 8. _____ |
| 4. _____ | 9. _____ |
| 5. _____ | 10. _____ |

ALLERGIES

- ___ Medications: _____
- ___ Foods: _____
- ___ Other: _____

SURGICAL HISTORY

Surgical procedures / serious injuries / illnesses	Year	Physician	Hospital

Has any **family member** had any of the following? Please indicate relationship:

- Cancer: _____ Diabetes: _____
- Heart disease: _____ Stroke: _____
- High blood pressure: _____ Vascular disease/circulatory problems: _____
- Other: _____

SOCIAL INFORMATION

Do you smoke currently? Yes No How many packs a day? _____ For how many years? _____
 Have you smoked previously? Yes No When did you quit: _____
 History of substance abuse? Yes No If yes, please list: _____
 Amount of alcohol consumed: Per week _____ Per month _____

MEDICAL CONDITIONS

Circle yes or no if these conditions **currently** apply to you:

Blackout / fainting	No	Yes	Headache	No	Yes
Bladder / bowel movement	No	Yes	High blood pressure	No	Yes
Bleeding problems	No	Yes	Lower back pain	No	Yes
Changes in skin color / texture	No	Yes	Lungs, breathing / cough	No	Yes
Chest pain/palpitation	No	Yes	Muscle / bone / joint pain	No	Yes
Digestion	No	Yes	Numbness / tingling	No	Yes
Ears, Nose, Throat	No	Yes	Swelling discoloration extremity	No	Yes
Eyes / visual disturbance	No	Yes	Weight loss or gain	No	Yes
Fever / chills / sweats / fatigue	No	Yes	Dizziness	No	Yes

I hereby authorize direct payment of surgical and medical benefits on my behalf to the provider of these services that I would otherwise be payable to me if I did not make this assignment. I understand that I am personally responsible to the physician for charges not covered by my insurance agreement. I permit a copy of this assignment to be used in place of the original for purposes of billing.

I acknowledge that if my insurance requires a referral, whether it be paper or electronic, that I am responsible for getting an up to date and valid referral.

The information provided by me is true to the best of my knowledge. I authorize release of any previous medical records by fax, mail or phone by either physician or hospital generated. Also, I hereby authorize the doctor or his assistants to initiate the diagnosis and treatment of my condition to use x-ray examination, or photographs as necessary.

I give Physicians Footcare permission to obtain and release medical information to insurance companies and referring physician. I have read the following and understand and agree to Physicians Footcare's office policy.

Date

Signature of patient or legal guardian

If not patient, relation to patient:

Parent Power of attorney Legal guardian Other: _____

NOTICE OF PRIVACY PRACTICES

We are committed to protecting your health information. This notice describes the ways in which we use and disclose information about you. It will also explain your rights to get access to your health information and the legal obligations we have regarding its control, protection, use and disclosure in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

We are required by law to:

- Maintain the privacy and security of your information
- Use your information for treatment, research, improvement of quality and patient care, share it with other healthcare professionals that are treating you, and bill for services
- Comply with law enforcement and government agencies including workers compensation and the public health department as required by state and federal laws
- Notify you in the event of a data breach

We will not:

- Sell your personal information for marketing purposes
- Voluntarily disclose any information without a signed release from you

When it comes to your health information, you have certain rights.

Your rights:

- Copies of your records within 30-days of making such request. Records are subject to our Medical Record Charges as determined by state law
- Ask us to correct health information about you. You will receive an answer to your request within 60 days
- Request confidential communications
- Ask us to limit what we share
- Ask us for a list of how your health information has been disclosed
- Receive a paper copy of this notice
- Choose someone to act on your behalf (durable power of attorney, legal guardian, etc.)
- File a complaint if you feel your rights are violated (we will not retaliate against you for filing a complaint)

Any use or disclosure of your protected health information (PHI) that is not mentioned in this notice will be made only with your written authorization. We will request that you sign a separate form entitled "Privacy Policy/Benefits Assignment/Release of Information" acknowledging that you have read a copy of this notice. The acknowledgment will be filed with your records.

PRIVACY POLICY

I have read the Physicians Footcare Notice of Privacy Practices and understand that my protected health information (PHI) may be released to other healthcare providers, hospitals, insurance companies, etc. as outlined in the policy, according to the Health Insurance Portability and Accountability Act of 1996 (HIPAA). A paper copy of the policy is available to me under my rights.

BENEFITS ASSIGNMENT

I hereby authorize payment of my insurance carrier directly to Physicians Footcare for any charges incurred for medical treatment at said facility in which care is rendered.

RELEASE OF INFORMATION

I also authorize the Physicians Footcare doctors and staff to talk to and release information to the following individuals regarding my healthcare. I understand that this release will remain in effect until I revoke it, which I may do at any time, in writing.

Spouse/partner: _____

Child/children: _____

Other: _____ Relationship: _____

Other: _____ Relationship: _____

By signing below, I certify that I have read and agree to the above.

Printed Name: _____

Signature: _____ *Date:* _____



24 HOUR CANCELLATION & "NO SHOW" FEE POLICY

Recognizing that everyone's time is valuable, and that appointment time is limited, we ask that you provide 24 hours advanced notice if you are unable to keep your appointment. Each time a patient misses an appointment without providing proper notice, another patient is prevented from receiving care. Therefore, Physicians Footcare reserves the right to charge a fee of \$25.00 for each missed ("no show") appointment which is not cancelled within a 24-hour advance notice.

"No show" fees will be billed to the patient. This fee is not covered by insurance and must be paid prior to your next appointment. Multiple "no shows" in any 12-month period can result in termination from our practice.

Thank you for your anticipated cooperation.

By signing below, I acknowledge that I have received this notice and understand this policy:

Printed Name: _____

Signature: _____ *Date:* _____