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: _____

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 _____

What is your shoe size? _____

Patient's Past or Current Medical Problems
*Please circle yes or no to those that apply to you **now** or **have applied to you in the past***:

Arthritis	No	Yes	Gout	No	Yes
Asthma	No	Yes	Headache	No	Yes
Back pain	No	Yes	Heart Disease	No	Yes
Blackout / fainting	No	Yes	Hepatitis	No	Yes
Bladder / bowel movement	No	Yes	Hypercholesterolemia	No	Yes
Bleeding disorder	No	Yes	Hypertension (high blood pressure)	No	Yes
Blood transfusion (year: _____)	No	Yes	HIV or other immune deficiency	No	Yes
Cancer	No	Yes	HX of blood clots	No	Yes
Changes in skin color / texture	No	Yes	Kidney disease	No	Yes
Chest pain/palpitation	No	Yes	Liver disorder	No	Yes
Deformity	No	Yes	Muscle / bone / joint pain	No	Yes
Diabetes	No	Yes	Numbness / tingling	No	Yes
Dialysis	No	Yes	Psychiatric problem	No	Yes
Digestion	No	Yes	Raynaud's disease	No	Yes
Dizziness	No	Yes	Respiratory (lung ____ cough ____)	No	Yes
Ears, Nose, Throat	No	Yes	Stroke	No	Yes
Epilepsy / seizure disorder	No	Yes	Swelling discoloration extremity	No	Yes
Eyes / visual disturbance	No	Yes	Thyroid disease	No	Yes
Fever / chills / sweats / fatigue	No	Yes	Ulcer (leg ____ foot ____)	No	Yes
Fibromyalgia	No	Yes	Varicose veins	No	Yes
Gastritis	No	Yes	Vascular disease / circulatory problems	No	Yes
GI disease (ulcers)	No	Yes	Weight loss or gain	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: _____

MEDICATIONS

*Please list **all** 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 the relationship:

Cancer: _____ Diabetes: _____

Heart disease: _____ Stroke: _____

Hypertensive disorder: _____ Peripheral vascular disease: _____

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 who 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 your 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-hour 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 that is not canceled 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 before your next appointment. Multiple "no-shows" in any 12 months 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:* _____