NEW PATIENT INFORMATION FORM

PATIENT INFORMATION

PATIENT NAME: ______________________ (LAST, FIRST, MI) DATE OF BIRTH: ___/___/___ (MM DD YYYY) AGE: ___ SEX: ☐ M ☐ F

HOME ADDRESS: ______________________ (STREET, CITY, STATE, ZIP) SS# __________

PHONE #: HOME (____) ____-______ WORK (____) ____-______ CELL (____) ____-______

E-MAIL: ______________________

PRIMARY CARE DOCTOR: ______________ PHONE #: (___) ____-______ LAST SEEN: __________

PHARMACY: ______________ LOCATION ______________ PHONE #: (___) ____-______

WHO REFERRED YOU TO US? ______________________

EMERGENCY CONTACT INFORMATION

EMERGENCY CONTACT: ______________ RELATIONSHIP: __________ PHONE#: (____) ____-______

IS THERE A FAMILY MEMBER OR OTHER PERSON YOU WOULD LIKE FOR US TO SHARE YOUR MEDICAL INFORMATION?

☐ YES ☐ IF YES, NAME: ______________ RELATIONSHIP __________ PHONE #: (____) ____-______

INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY NAME: ______________________

ADDRESS: ______________________ (STREET, CITY, STATE, ZIP) PHONE #: (____) ____-______

INSURED NAME: ______________ DATE OF BIRTH __________ RELATIONSHIP TO PATIENT __________

EMPLOYER NAME ______________ POLICY # __________ GROUP # __________

SECONDARY INSURANCE COMPANY NAME: ______________________

ADDRESS: ______________________ (STREET, CITY, STATE, ZIP) PHONE #: (____) ____-______

INSURED NAME: ______________ DATE OF BIRTH __________ RELATIONSHIP TO PATIENT __________

EMPLOYER NAME ______________ POLICY # __________ GROUP # __________

ALLERGIES

☐ FOODS ______________ ☐ TAPE ☐ LATEX ☐ SHELLFISH ☐ IODINE

☐ MEDICATIONS ______________ ☐ ANESTHESIA ______________

☐ OTHER ______________ ☐ NONE KNOWN

MEDICATIONS

PLEASE LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING (INCLUDE PRESCRIPTIONS, OVER-THE-COUNTER AND HERBAL SUPPLEMENTS):

______________ ______________ ______________

______________ ______________ ______________

______________ ______________ ______________

PATIENT NAME: ______________________________

MEDICAL HISTORY

PLEASE CHECK THE BOX IF YOU CURRENTLY OR IN THE PAST HAVE HAD THE FOLLOWING SYMPTOMS:

ARTHRITIS:	☐ RHEUMATOID ☐ OSTEO ☐ GOUT ☐ OTHER
EENT:	☐ TONSILLITIS ☐ GLAUCOMA ☐ CATARACTS ☐ EYE /VISION DIS. ☐ HEADACHES ☐ MIGRAINES ☐ HEARING DEFICIT
GASTROINTESTINAL:	☐ ULCERS ☐ REFLUX ☐ HERNIA ☐ BOWEL DIS. ☐ IRRITABLE BOWEL SYN. ☐ HEMORRHOIDS ☐ GI BLEEDING
GENITO-URINARY:	☐ KIDNEY OR BLADDER INFECTIONS ☐ KIDNEY STONES ☐ PROSTATE DISORDER ☐ STD
MAJOR ILLNESSES:	☐ DIABETES TYPE I /TYPE II ☐ HYPERCHOLESTROLEMIA ☐ HYPERTENSION ☐ CHEST PAIN ☐ MI ☐ CANCER ☐ MITRAL VALVE PROLAPSE ☐ HEART MURMUR ☐ ARRHYTHMIA ☐ STROKE ☐ CHF ☐ PACEMAKER ☐ HEART DISEASE
PSYCHOLOGICAL:	☐ ANXIETY ☐ DEPRESSION ☐ PSYCHIATRIC CONDITION ☐ DRUG OR ALCOHOL DEPENDENCY
RESPIRATORY:	☐ ASTHMA ☐ TUBERCULOSIS ☐ EMPHYSEMA ☐ SINUS PROBLEMS ☐ SHORTNESS OF BREATH ☐ COPD ☐ LUNG DISEASE
SKIN DISORDERS:	☐ PSORIASIS ☐ SKIN CANCER
VASCULAR DISEASE/BLOOD DISORDERS:	☐ POOR CIRCULATION ☐ SICKLE CELL ☐ PERIPHERAL VASCULAR DISEASE ☐ LEG OR CALF PAIN ☐ NIGHT CRAMPS ☐ REST PAIN ☐ VEIN PROBLEMS ☐ SWELLING ☐ VARICOSE VEINS ☐ PHLEBITIS ☐ LEG ULCERS ☐ BLOOD CLOT ☐ DVT ☐ PE ☐ ANEMIA ☐ BLEEDING OR CLOTTING DISORDERS ☐ EASY BRUISING ☐ TRANSFUSIONS
OTHER ILLNESSES:	☐ EPILEPSY OR SEIZURES ☐ THYROID DISEASE ☐ MUSCLE DISEASE ☐ HEPATITIS ☐ HIV OR AIDS ☐ LYME DISEASE ☐ OTHER: ______________________
OTHERS:	**ARE YOU PREGNANT?** ☐ YES ☐ NO **ARE YOU NURSING?** ☐ YES ☐ NO **HEIGHT:** ______________ **WEIGHT:** ______________

SURGICAL HISTORY

PLEASE LIST ALL PRIOR SURGERIES:

TYPE OF SURGERY	DATE	TYPE OF SURGERY	DATE

SOCIAL HISTORY

USE OF ALCOHOL: ☐ NEVER ☐ NO LONGER USE ☐ HISTORY OF ALCOHOL ABUSE
☐ CURRENT USE - TYPE __________ ☐ RARE ☐ OCCASIONAL ☐ MODERATE ☐ DAILY

USE OF TOBACCO: ☐ NEVER ☐ QUIT – HOW LONG AGO? _______ ☐ SMOKE ___ PACKS/DAY FOR ___ YEARS

USE OF RECREATIONAL DRUGS: ☐ NEVER ☐ QUIT – HOW LONG AGO? _______ TYPE ______________
☐ CURRENT USE - TYPE __________ ☐ RARE ☐ OCCASIONAL ☐ DAILY

EMPLOYER: ______________________ OCCUPATION: ______________________

PATIENT NAME: ____________________

FAMILY HISTORY

DO YOU HAVE A FAMILY HISTORY OF:	☐ DIABETES: TYPE 1 OR TYPE 2	☐ CANCER
☐ THYROID DISEASE	☐ HIGH BLOOD PRESSURE	☐STROKE
☐ CORONARY ARTERY DISEASE	☐ RHEUMATOID ARTHRITIS	☐ OTHER __________

CURRENT PROBLEM

WHAT SPECIFIC PROBLEM BRINGS YOU TO OUR OFFICE TODAY? ____________________

WHERE IS THE PAIN/PROBLEM LOCATED? PLEASE MARK ON THE PICTURES BELOW.

LEFT FOOT

TOP OF FOOT

BOTTOM OF FOOT

INSIDE OF FOOT

OUTSIDE OF FOOT

RIGHT FOOT

BOTTOM OF FOOT

TOP OF FOOT

OUTSIDE OF FOOT

INSIDE OF FOOT

PLEASE READ THE ACKNOWLEDGEMENT ON THE NEXT PAGE AND SIGN IT. THANK YOU.

TO THE BEST OF MY KNOWLEDGE, I HAVE ANSWERED THE QUESTIONS ON THIS FORM ACCURATELY. I UNDERSTAND THAT PROVIDING INCORRECT INFORMATION CAN BE DANGEROUS TO MY HEALTH. I UNDERSTAND THAT IT IS MY RESPONSIBILITY TO INFORM THE DOCTOR AND OFFICE STAFF OF ANY CHANGES IN MY MEDICAL STATUS.

____________________ PRINT NAME OF PATIENT, PARENT OR GUARDIAN

____________________ SIGNATURE

____________________ IF OTHER THAN PATIENT, RELATIONSHIP TO PATIENT

____________________ DATE

PATIENT HIPAA ACKNOWLEDGEMENT AND DESIGNATION DISCLOSURE FORM

I. **Acknowledgement of Practice's *Notice of Privacy Practices*:**
By subscribing my name below, I acknowledge that I was provided a copy of the Notice of Privacy Practices (NPP). and that I have read (or had the opportunity to read if I so chose) and understand the Notice of Privacy Practices (NPP) and agree to its terms.

Name of Patient	**Date of Birth**	**Signature of Patient/Parent/Guardian**

II. **Designation of Certain Relatives, Close Friends and other Caregivers as my Personal Representative:**
I agree that the practice may disclose certain of my health information to a Personal Representative of my choosing, since such person is involved with my health care or payment relating to my health care. In that case, the Physician Practice will disclose only information that is directly relevant to the person's involvement with my health care or payment relating to my health care.

Print Name:_____________________________**Last four digits SSN (required):**____________
Print Name:_____________________________**Last four digits SSN (required):**____________
Print Name:_____________________________**Last four digits SSN (required):**____________

III. **Request to Receive Confidential Communications by Alternative Means:**
As provided by Privacy Rule Section 164.522(b), I hereby request that the Practice make all communications to me by the alternative means that I have listed below.

Home Telephone Number: ________________________

____ OK to leave message with detailed information
____ Leave message with call back numbers only

Written Communication Address: ________________________

____ OK to mail to address listed above
____ E-mail me at:____________________

Work Telephone Number: ________________________

___ OK to leave message with detailed information
____ Leave message with call back numbers only

Fax Number: ________________________

____ OK to Fax at the number listed above
____ E-mail me at:____________________

Other:____

Name of Patient (Printed)	Signature of Patient/Parent/Guardian
Witness signature	Date

E-PRESCRIBING CONSENT

E-PRESCRIBING IS DEFINED BY A PHYSICIANS ABILITY TO ELECTRONICALLY SEND AN ACCURATE, ERROR FREE, AND UNDERSTANDABLE PRESCRIPTION DIRECTLY TO YOUR PHARMACY. CONGRESS HAS DETERMINED THAT THE ABILITY TO ELECTRONICALLY SEND PRESCRIPTIONS IS AN IMPORTANT ELEMENT IN IMPROVING THE QUALITY OF PATIENT CARE. EPRESCRIBING GREATLY REDUCES MEDICATION ERRORS AND ENHANCES PATIENT SAFETY. THE MEDICARE MODERNIZATION ACT 2003, LISTED STANDARDS THAT HAVE TO BE INCLUDED IN AN E-PRESCRIBING PROGRAM. THESE INCLUDE:(1) FORMULARY AND BENEFIT TRANSACTIONS, WHICH GIVES THE PRESCRIBER INFORMATION ABOUT WHICH DRUGS ARE COVERED BY A DRUG BENEFIT PLAN;(2) MEDICATION HISTORY TRANSACTIONS, WHICH PROVIDES THE PHYSICIAN WITH INFORMATION ABOUT MEDICATIONS THE PATIENT IS ALREADY TAKING TO MINIMIZE ADVERSE DRUG EVENTS. I AUTHORIZE **FLORENCE FOOT AND ANKLE CENTER**, TO VIEW MY EXTERNAL PRESCRIPTION HISTORY VIA ELECTRONIC E-PRESCRIBING SERVICES. I UNDERSTAND THAT PRESCRIPTION HISTORY FROM MULTIPLE, OTHER UNAFFILIATED, PROVIDERS, INSURANCE COMPANIES, PHARMACIES AND PHARMACY BENEFIT MANAGERS MAY BE VIEWABLE BY THE PROVIDERS AND STAFF OF **FLORENCE FOOT AND ANKLE CENTER**, AND IT MAY INCLUDE PRESCRIPTIONS BACK IN TIME FOR SEVERAL YEARS AND MAY INCLUDE PRESCRIPTIONS TO TREAT HIV, SUBSTANCE ABUSE AND PSYCHIATRIC CONDITIONS. IF APPLICABLE, I UNDERSTAND THAT MY PRESCRIPTION HISTORY WILL BECOME PART OF MY RECORD AT THIS PRACTICE. UNDERSTANDING ALL OF THE ABOVE, I HERBY PROVIDE INFORMED CONSENT TO **FLORENCE FOOT AND ANKLE CENTER** TO ENROLL ME IN THE E-PRESCRIBE PROGRAM. THIS CONSENT WILL REMAIN ENFORCED UNTIL REVOKED OR CHANGED.

PATIENT SIGNATURE____

PARENT/LEGAL GUARDIAN SIGNATURE___________________________________

I CERTIFY, TO THE BEST OF MY KNOWLEDGE, I HAVE ANSWERED THE QUESTIONS ON THIS FORM ACCURATELY. I UNDERSTAND THAT PROVIDING INCORRECT INFORMATION CAN BE DANGEROUS TO MY HEALTH. I UNDERSTAND THAT IT IS MY RESPONSIBILITY TO INFORM THE DOCTOR AND OFFICE STAFF OF ANY CHANGES IN MY MEDICAL STATUS.

I GIVE PERMISSION TO THE DOCTORS AT **FLORENCE FOOT AND ANKLE CENTER** TO ADMINISTER AND PERFORM ANY DIAGNOSTIC, THERAPEUTIC AND/OR OPERATIVE PROCEDURES AS MAY BE DEEMED MEDICALLY NECESSARY IN DIAGNOSIS AND/OR TREATMENT OF MY CONDITION.

PATIENT/MINORS UNDER THE AGE OF 18, WILL NOT BE TREATED WITHOUT A PARENT OR LEGAL GUARDIAN PRESENT. IF ANOTHER FAMILY MEMBER, CARE TAKER OR FRIEND, OVER THE AGE OF 18 WILL BE PRESENT; WRITTEN CONSENT FROM THE PARENT/LEGAL GUARDIAN STATING AS SUCH MUST BE PRESENTED AT THE TIME OF THE APPOINTMENT. THANK YOU.

NAME OF PATIENT ____________________ PATIENT SIGNATURE ____________________

NAME OF PARENT/LEGAL GUARDIAN __________ PARENT/LEGAL GUARDIAN SIGNATURE__________

FINANCIAL POLICY

Thank you for choosing our office to provide you with medical care. We are committed to serving you with skill and high quality care. The medical services provided by our office are services you have elected to receive which may imply a financial responsibility on your part.

INSURANCE: We participate in most insurance plans. If you are not insured by a plan we participate with, payment in full is expected at each visit. If you are insured by a plan we participate with but do not have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.

MEDICARE: We are a participating Medicare provider. Medicare as well as your secondary insurance (if any) will be billed for you. However; that does not mean that all services are covered. Patients are responsible for paying their annual deductible if it has not yet been met. You are also responsible for any coinsurance, which is usually 20% of the allowed amount for an item or service.

SECONDARY INSURANCE: Your medical claim will be forwarded to your secondary insurance (if any) after payment and/or explanation of benefits (EOB) is received from your primary insurance company.

COPAYMENTS AND DEDUCTIBLES: All co-payments and deductible must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your co-payment at each visit.

SELF PAY: Payment in full is due at the time of service if you do not have health insurance.

NON-COVERED SERVICES: Please be aware that some of the services you receive may not be covered or not considered reasonable or necessary by Medicare or other insurers. You are responsible for payment of these services.

REFERRALS/AUTHORIZATIONS: We are required to follow the guidelines of your managed care plan which mandates us that when you visit a specialist such as ours, you must have a referral from your primary care physician prior to seeking specialty care. Obtaining referrals from your primary physician and keeping track of your visits is your responsibility. If you do not have a valid referral at the time of your visit, your appointment will be rescheduled.

CLAIM SUBMISSION: We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility. Your insurance benefit is a contract between you and your insurance company.

PATIENT BILLING: You will be sent up to three notices for your financial responsibility (co-insurance, deductible) after payment and/or explanation of benefits (EOB) is received from your insurance company/companies. After the third and last notice, your account may be forwarded to collections with interest accruing on balance. It is also your responsibility to pay for the interest accrued if sent to collections. Please let the billing office know if you have any difficulties resolving your bill. Payment arrangements can be made on a case by case basis. We accept the following payment methods: Cash, Credit/Debit Cards, Checks. An additional $25.00 will be added to your statement if the check is returned for insufficient funds. In the event that your insurance company should happen to send payment to you, the patient, we expect that you would forward it to our office to be applied to your balance.

I have read the above policy regarding my financial responsibility to **FLORENCE FOOT AND ANKLE CENTER** for medical services provided. I agree to pay **FLORENCE FOOT AND ANKLE CENTER** any balance unpaid by my insurance carrier for myself or the below named person.

Assignment of Benefits

I, the undersigned, certify that I (or my dependent) have coverage with my insurance as presented and assign directly to **FLORENCE FOOT AND ANKLE CENTER** all insurance benefits, payable to me for services rendered. I understand that I am responsible for payment of deductibles, co-payments, and/or non-covered services. I hereby authorize the doctor to release all information necessary to secure payment of benefits. I authorize RELEASE OF MEDICAL INFORMATION to my insurance carrier, or requested physician to provide continuity of care. I authorize the use of this signature on all insurance submissions.

PRINT Patient Name: ____________________ Signature: ____________________

FINANCIALLY RESPONSIBLE PARTY:

PRINT Name: ____________________________ Signature: ____________________

Relationship to Patient: ______________________________ Date: __________________