DUNES PODIATRY LLC

PATIENT INFORMATION Please Complete ALL Information

Name:_____**SS#**_____

DOB:_____ **Age** _____ **Height** _____ **Weight** _____ **Marital Status**: S M D W **Sex**: M F

Mailing Address:_____**City/State**_____**Zip Code**_____

Home Ph:_____ **Work Ph**: _____**Cell**:_____

Email Address: _____

Race: (Please Circle) American Indian/Alaskan Native, Asian, Black/African American, Hispanic/Latino, Native Hawaiian/Other Pacific Islander, White

Whom may we thank for referring you to us: (Please Circle) Valpak, Newspaper, Friend, Physician, Other
Name of Individual_____

Chief complaint for which you came to be treated: (Please Circle) Diabetic Check, Nails, Heel pain, Foot Pain, Burning Feet, Plantar Warts, Corn/Calluses, Bunions, Athlete's Foot, Ankle Pain, Other (explain below)_____

Foot problems you have had in the past: (Please Circle) Ankle Pain, Corns/Calluses, Flat Feet, Plantar Warts, Cramps, Athlete's Foot, Heel Pain, Swelling, Bunions, Numbness, Ingrown Nails, Tired Feet

Personal or family history of diabetes: Y N **Have you ever been to a podiatrist before?**_____

If yes, please list Name:_____ **Last Visit Date:** _____

Cigarette/Tobacco Use: Y N **If yes, how many years smoked?**_____ **# packs per day**_____

FINANCIAL INFORMATION:

Patient's Employer:_____ **Spouse's Employer**:_____
Primary Insurance Carrier _____ **Secondary** _____
Is this through an employer? Y N **If yes, name of employer** _____
Insured Party_____ **Relationship to Patient** _____**DOB**_____
EMERGENCY CONTACT: Name_____ Relationship _____Phone _____

INSURANCE & MEDICARE AUTHORIZATION: I hereby authorize Dunes Podiatry LLC to furnish information to Insurance/Medicare carriers concerning my illness and hereby assign to the physician all payments for medical services rendered to myself or my dependents. I understand that I am responsible for any amount not covered by insurance. As your insurance policy is a contract between you & your insurance company any insurance deductibles are your responsibility, including Medicare deductibles. If your insurance company has not paid within 45 days, the balance will be your responsibility which must be paid within 30 days after that time. Out of Pocket expenses require full payment at time of service unless other arrangements are made prior to appointment. Co-pays are due at time of service. Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area.

Date:_____ **Signature** _____

MEDICAL HISTORY (Please check yes or no):

AIDS/HIV	□ Yes □ No	Fainting	□ Yes □ No	Respiratory Disease	□ Yes □ No
Anemia	□ Yes □ No	Foot/Leg Cramps	□ Yes □ No	Rheumatic Fever	□ Yes □ No
Arthritis	□ Yes □ No	GI Issues	□ Yes □ No	Shortness of Breath	□ Yes □ No
Artificial Heart Valves	□ Yes □ No	Gout	□ Yes □ No	Sinus Problems	□ Yes □ No
Artificial Joints	□ Yes □ No	Headaches	□ Yes □ No	Stroke	□ Yes □ No
Asthma	□ Yes □ No	Heart Disease	□ Yes □ No	Swelling Feet/Ankles	□ Yes □ No
Back Problems	□ Yes □ No	Hemophilia	□ Yes □ No	Swollen Glands	□ Yes □ No
Bleeding Problems	□ Yes □ No	Hepatitis	□ Yes □ No	Thyroid Problems	□ Yes □ No
Cancer	□ Yes □ No	High Blood Pressure	□ Yes □ No	Tired Feet	□ Yes □ No
Chemical Dependency	□ Yes □ No	High Cholesterol	□ Yes □ No	Tuberculosis	□ Yes □ No
Chest Pain	□ Yes □ No	Kidney Problems	□ Yes □ No	Ulcers	□ Yes □ No
Circulatory Problems	□ Yes □ No	Liver Problems	□ Yes □ No	Varicose Veins	□ Yes □ No
Clotting Problems	□ Yes □ No	Low Blood Pressure	□ Yes □ No	Venereal Disease	□ Yes □ No
Diabetes	□ Yes □ No	Nervous Problems	□ Yes □ No		
Epilepsy	□ Yes □ No	Psychiatric Care	□ Yes □ No		
Eye Problems	□ Yes □ No	Radiation Treatment	□ Yes □ No		

Surgeries you have had:_____

Hospitalizations, other than for the surgeries:_____

Family Physician:_____ **Last Visit Date:**_____

Are you now, or have you been, under any other doctor's care for any reason over the past two years? Y N
If yes, please explain:_____

MEDICATIONS (prescriptions, over-the-counter & vitamins)

_____ _____ _____

_____ _____ _____

ALLERGIES/REACTION

○ Adhesive Tape ○ Aspirin ○ Codeine ○ Demerol ○ Iodine ○ Local Anesthetics ○ Novocaine
○ Pencillin ○ Seafoods ○ Sulfa Drugs ○ None ○ Other_____

CONSENT/HIPAA NOTICE OF PRIVACY PRACTICES

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 authorize Dunes Podiatry LLC to use and disclose the protected health information for both treatment and for payment of services rendered by all doctors of Dunes Podiatry LLC. This medical information may be used by the person I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposed as I may direct. I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has legal right to contest a claim. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by state or federal law.

Patient Signature _____**Date**_____