SUNSHINE PODIATRY 11918 Balm Riverview Rd, Riverview, FL 33569

Patient Demographic Form

Please PRINT, bring with you to your visit or return via fax to 813-658-6238, do not E-mail.
Please bring **CURRENT** insurance ID cards and a photo ID.

PATIENT INFORMATION

Last Name | **First Name** | **Middle Initial** | **Title/Degree**

Date of Birth | **Gender** ❑ Male ❑ Female

Marital Status ❑ Married ❑ Single ❑ Divorced ❑ Life Partner ❑ Separated ❑ Widowed ❑ Other **Language** other than English

Race (Optional) ❑ Black – Non Hispanic ❑ American Indian/ Alaskan Native ❑ Hispanic ❑ Asian/Pacific Islander ❑ White – Non Hispanic ❑ Other

Home Address | **Apt #** | **City** | **State** | **Zip Code**

Home Phone | **Work Phone** | **Mobile Phone**

Email Address | **Employment Status** ❑ Active Duty Military ❑ Child ❑ Disabled ❑ Employed Full-Time ❑ Employed Part-Time ❑ Homemaker ❑ Not Employed ❑ Retired ❑ Self Employed ❑ Student Full-Time ❑ Student Part-Time ❑ Other | **Employer** | **Employer Phone**

Primary Care Physician:_____

Preferred Pharmacy:_____

Is Patient Enrolled in Hospice? **Yes** **No**

REFERRAL INFORMATION

Referring Physician (Required for some insurance plans):_____

How did you hear about us? ❑ Google ❑ Insurance ❑ Family ❑ Friend ❑ Health Fair Event ❑ Employer ❑ Magazine ❑ Mail ❑ News ❑ Other:_____

RESPONSIBLE PARTY (PRIMARY INSURED ON INSURANCE) INFORMATION

Relationship to Patient ❑ Self (If self, skip to Emergency / Next of Kin) ❑ Spouse ❑ Parent ❑ Other

Last Name | **First Name** | **Middle Initial**

Date of Birth | **Social Security Number(optional)**

Home Address | **Apt #** | **City** | **State** | **Zip Code**

Home Phone | **Work Phone** | **Mobile Phone**

Power of Attorney (if different from above):

EMERGENCY / NEXT OF KIN CONTACT INFORMATION

Last Name | **First Name** | **Relationship to Patient**

Address | **Apt #** | **City** | **State** | **Zip Code**

Home Phone | **Work Phone** | **Mobile Phone**

OTHER CONTACT INFORMATION – NOT LIVING WITH PATIENT

Last Name | **First Name** | **Relationship to Patient**

Address | **Apt #** | **City** | **State** | **Zip Code**

Home Phone | **Work Phone** | **Mobile Phone**

REASON FOR VISIT

Primary reason for visit today: _____
_____

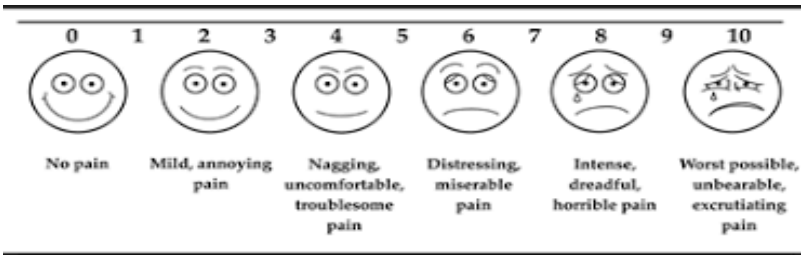
Which side? Left / Right / Both

How long has the problem been present? _____

Is this related to an injury? Yes / No

If yes, please state date of injury __/__/____ and brief description:_____
_____

Pain level (0 to 10): _____



What treatment have you tried to alleviate the problem/pain? _____
_____
_____
_____

Other concerns: _____

For diabetics ONLY:

-Date of last visit with primary care doctor or endocrinologist: ____/___/_____

-Duration of diabetes: _____

-Last HbA1c reading: _____

-Last morning fingerstick glucose reading: _____

-Loss of feeling in feet? YES / NO

-Prior ulcerations or foot infections? YES / NO

-Leg/calf/foot pain with long distance walking? YES / NO

MEDICAL HISTORY QUESTIONNAIRE

PATIENT NAME: _____
Height: _____ Weight: _____lbs Shoe size: _____N / M / W / XW

ALLERGIES: □ No known drug allergies

Allergy	Reaction	Allergy	Reaction
1.		4.	
2.		5.	
3.		6.	

CURRENT MEDICATIONS (or provide list): □ None

Medication	Dose (mg, #pills, etc)/ Times Per Day	Medication	Dose (mg, #pills, etc)/ Times Per Day
1.		6.	
2.		7.	
3.		8.	
4.		9.	
5.		10.	

MEDICAL HISTORY (or provide list): □ None

Diagnosis	Year Diagnosed	Additional Information

SURGICAL HISTORY (or provide list): □ None

Surgery	Approximate Date of Surgery	Surgeon and/or Location

FAMILY HISTORY □ None or unknown

Relationship		Significant Health History (Heart disease, Diabetes, Cancer, foot/ankle problems etc)
Father		
Mother		
Siblings		

SOCIAL HISTORY

Cigarette Smoking	□ Yes	□ No	Years smoked: Pack/Day: Year Quit:
E-cigarettes	□ Yes	□ No	Contains nicotine? □ Yes □ No
Alcohol Consumption	□ Yes	□ No	□ Socially □ Daily □ Weekly Drinks/Day or Week:
Recreational Drugs	□ Yes	□ No	Drug name:
Occupation: _____ _____	□ Retired	□ Disabled	Job activity (select all that apply): □ sitting □ standing □ walking □ driving □ heavy lifting □ work from home □ can sit if needed

REVIEW OF SYSTEMS

CHECK ALL THAT APPLY:

CONSTITUTION		**GASTROINTESTINAL**		**SKIN**	
	Appetite Change		Blood in stool		Skin color changes
	Chills		Constipation		Rash
	Fevers		Diarrhea		Wound
	Fatigue		Nausea/Vomitting		Nail color changes
	Unexpected Weight Change		C. difficile infection		Skin cancer
			Heart burns		
RESPIRATORY			NSAIDs intolerance	**ALLERGY/IMMUNO**	
	Chest Tightness		GI ulcers		Immunocompromised
	Cough		Liver disease/jaundice		History of organ transplant
	Shortness of Breath				
	Wheezing	**ENDOCRINE**		**INFECTIOUS DISEASES**	
			Frequent thirst		HIV+
CARDIOVASCULAR			Frequent urination		Hepatitis: A B C
	Chest Pain		Frequent hunger		COVID-19 Exposure last 14 days
	Leg Swelling		High blood sugar		
	Leg Pain		Cold/heat intolerance	**HEMATOLOGIC**	
	Cold feet		Diabetes		Bruises easily
	Varicose veins				Anemic
	Leg ulcers	**MUSCULOSKELETAL**			Slow to heal
	Calf pain with walking		Joint pain/stiffness		
	Prior Heart attack		Joint swelling/redness	**NEUROLOGICAL**	
			Foot pain		Dizziness
GENITOURINARY			Problems with walking		Prior Stroke/TIA
	Kidney disease		Foot/Ankle deformity		Numbness in hands/feet
	Kidney transplant		Foot/Ankle injury		Tingling in hands/feet
	Dialysis				Burning in hands/feet
	Burning with urination				Weakness
					Poor balance
					Seizures
					Contractures

Sunshine Podiatry LLC

GENERAL CONSENT and POLICIES

I, _____, consent to evaluation and treatment of the condition for which I, my child or dependent, have come to Sunshine Podiatry LLC, and authorize the physicians and other health care providers affiliated with Sunshine Podiatry LLC, to provide such evaluation and treatment. I understand that health care providers in training may be involved in my care and treatment and consent to their involvement. I understand that the practice of medicine is not an exact science, and acknowledge that no guarantees have been made to me regarding the likelihood of success or outcomes of any examination, treatment, diagnosis, or test performed at or by Sunshine Podiatry LLC. I acknowledge and agree that this consent will be applicable to all visits or episodes of evaluation and treatment at Sunshine Podiatry LLC. I have had an opportunity to discuss it, and any questions I have had have been answered to my complete satisfaction.

MISSED APPOINTMENT POLICY: I acknowledge that if I miss an appointment without giving advance notice I will be a charged a $40 no-show fee. I also acknowledge that if I accumulate 3 or more missed appointments without prior notification, my relationship with the practice may be terminated.

PATIENT FINACIAL RESPONSIBILITY POLICY: Sunshine Podiatry LLC reserves the right to collect fees for services at time of service in accordance with any applicable patient medical insurance benefits and estimated patient financial responsibility. This includes co-pay, co-insurance and deductibles for services rendered. The collected amount may not represent final patient responsibility as patient benefits and insurance fee schedule can change. It is the patient's responsibility to inquire regarding estimated fees for services offered prior to accepting such services. Billing statements for remaining balance or refunds for overpayment are processed pending final adjudication of medical claims and may take up to 180 days due to errors, appeals, or resubmission of claims. Unpaid statements may be referred to a collection agency.

Signature of Patient, Parent or Legal Guardian: _____

Date:_____

Sunshine Podiatry LLC HIPAA Notice of Privacy Practices

(Please retain this notice for your records)

This notice describes how medical information about you may be used and disclosed, and how you can gain access to this information. Please review it carefully. Protected Health Information (PHI), about you, is maintained as a written and/or electronic record of your contacts or visits for healthcare services with Sunshine Podiatry LLC. Specifically, PHI is information about you, including demographic information (i.e., name, address, phone, etc.), that may identify you and relates to your past, present or future physical or mental health condition and related healthcare services. Sunshine Podiatry LLC is required to follow specific rules on maintaining the confidentiality of your PHI, using your information, and disclosing or sharing this information with other healthcare professionals involved in your care and treatment. This Notice describes your rights to access and control your PHI.

Your Health Information Rights
Inspect and Copy: You have the right to inspect and copy the protected health information that we maintain about you in our designated record set for as long as we maintain that information. This designated record set includes your medical and billing records, as well as any other records we use for making any decision about you. Any psychotherapy notes that may have been included in records we received about you are not available for your inspection or copying by law. We may charge you a fee for the costs of copying, mailing, or other supplies used in fulfilling your request. If you wish to inspect or copy your medical information, you must submit your request in writing to our practice manager. You may mail in your request, or bring it to our office. We will have 30 days to respond to your request for information that we maintain at our practice site.

Request Amendment: You have the right to request that we amend your medical information if you feel that it is incomplete or inaccurate. You must make this request in writing to our practice manager, stating exactly what information is incomplete or inaccurate and the reasoning that supports your request. We will respond in writing within 60 days of your request. We are permitted to deny your request if it is not in writing or does not include a reason to support the request. We may also deny your request if: The information was not created by us, or the person who created it is no longer available to make the amendment; The information is not part of the record which you are permitted to inspect and copy: The information is not part of the designated record set kept by this practice; or if it is the opinion of the health care provider that the information is accurate and complete. We will respond within 60 days, in writing, explaining of the request was accepted or denied. Request an alternative means of confidential communication: You have the right to ask us to contact you about medical matters using an alternative method (i.e., email, telephone), and to a destination (i.e., cell phone number, alternative address, etc.) designated by you. You must inform us in writing, {using a form provided by our practice}, how you wish to be contacted if other than the address/phone number that we have on file. We will follow all reasonable requests.

Request a restriction of your PHI: This means you have the right to ask us, in writing, not to use or disclose any part of your Protected Health Information for the purposes of treatment, payment or healthcare operations. If we agree to the requested restriction, we will abide by it, except in emergency circumstances when the information is needed for your treatment. In certain cases, we may deny your request for a restriction. You will have the right to request, in writing, that we restrict communication to your health plan regarding a specific treatment or service that you, or someone on your behalf, has paid for in full, out-of-pocket. We are not permitted to deny this specific type of requested restriction.

An accounting of Disclosure: You have the right to request a list of the disclosures of your health information we have made outside of our practice that were not for treatment, payment, or health care operations. Your request must be made in writing and must state the time period for the requested information. You may not request information for any dates greater than six years (our legal obligation to retain information).

A Paper copy of This Notice: You have the right to receive a paper copy of this notice upon request. You may obtain a copy by asking our receptionist at your next visit by calling and asking us to mail you a copy.

File a Complaint: If you believe we have violated your medical information privacy rights, you have the right to file a complaint with us, or directly to the Secretary of Health and Human services. U.S. Department of Health and Human Services.

Authorize other use and disclosure: You have the right to authorize any use or disclosure of PHI that is not specified within this notice. You may revoke an authorization, at any time, in writing, except to the extent that your healthcare provider, or our practice, has taken an action in reliance on the use or disclosure indicated in the authorization. We may contact you to provide information about health related benefits and services offered by our office, for fundraising activities, share information in a disaster relief situation, include your information in a hospital directory, or with respect to a group health plan, to disclose information to the health plan sponsor. You will have the right to opt out of such special notices, and each such notice will include instructions for opting out.

Ways in Which We May use and Disclose Your Protected Health Information
The following paragraphs describe different ways that we use and disclose your protected health information. We have provided an example for each category, but these examples are not meant to be exhaustive. We assure you that all of the ways we are permitted to use and disclose your health Information fall within one of these categories.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. We will also disclose your health information to other physicians who may be treating you. Additionally, we may from time to time disclose your health information to another physician whom we have requested to be involved in your care. For example, we should disclose your health information to a specialist to whom we have referred you for a diagnosis to help in your treatment.

Health care operations: We will use and disclose your protected health information to support the business activities of our practice. For example – we may use medical information about you to review and evaluate our treatment and services or to evaluate our staff's performance while caring for you. In addition, we may disclose your health information to third- party business associates who perform billing, consulting, or transcription services for our practice.

Payment: We will use and disclose your protected health information to obtain payment for the health care services we provide you. For example, - we may include information with a bill to a third party payer that identifies you, your diagnosis, procedures performed, and supplies used in rendering the service.

Other Ways We May Use and Disclose Your Protected Health Information
Public health: We will use and disclose your protected health information in certain situations to help with public health and safety issues. Some of the situations include: Preventing disease, helping with product recalls, reporting adverse reactions to medications, reporting suspected abuse, neglect, or domestic violence, Preventing or reducing a serious threat to anyone's health or safety.

Research: We will use and disclose your protected health information to researchers provided the research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your health information. As Required by Law: We will use and disclose your protected health information when required to by federal, state, or local law. You will be notified of any such disclosures.

Other Permitted and Required Uses and Disclosures: We are also permitted to use or disclose your PHI without your written authorization for the following purposes: To comply with Food and Drug Administration requirements, Legal proceedings, Coroners, Funeral directors, Organ donation, Criminal activity, Military activity, National security, Worker's compensation, When an inmate is in a correctional facility, If requested by the Department of Health and Human Services in order to investigate or determine our compliance with the requirements of the Privacy Rule.

Our Responsibilities: We are required by law to maintain the privacy and security of your protected health information. We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information. We must follow the duties and privacy practices described in this notice and give you a copy of it. We will not use or share your information other than as described here unless you tell us we can in writing.
By signing this form you acknowledge you were advised of the HIPAA Notice of Privacy Practices. Our HIPAA Notice of Privacy Practices provides information about how we may use and disclose your protected information. We encourage you to read it in full. Our Notice of Privacy Practices is subject to change. You may request a copy of the Notice of Privacy.