NEW PATIENT INFORMATION FORM

DATE: __/__/__ First: _____ Last:_____

DOB:___/___/___ AGE: ____ SEX: __M __F SS#:_____

Email: _____

Primary Dr: _____ Phone# _____Last Visit: _____

Pharmacy: _____ Pharmacy #: _____

Home Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Alternate phone #_____

Employer: _____ Occupation:_____

Spouse's Name: _____

Primary Insurance: _____ ID#: _____ Group#: _____

Cardholder: _____ SS#: _____ DOB: __/__/__

Secondary Insurance: _____ ID#: _____ Group #: _____

Cardholder: _____ SS#: _____ DOB: __/__/__

Emergency Contact: _____
Is this Workers Comp or Accident related? YES / NO _____
_____
Have you recently been seen another podiatrist: __Y___N When: _____
Dr: _____

Current Problems:
_____

Length of time for current problem: ___Days ___Weeks ___Months ___Years

CURRENT MEDICATIONS

_____ _____ _____

_____ _____ _____

Are you currently taking any of the following:

__ Echinacea __Garlic __Ginger __Gingko Biloba __St. John's Wort __Ginseng __Feverfew __Ephedra

---

Immunization Status: __Polio __DPT/DtaP __Measles __MMR __Hep B __Varicella

Tetanus Status: __Current __Over 5 years __Over 10 years __Unknown

---

Vital Signs Height __ft __in Weight _____ BP _____ Temp. _____

Allergies:

	Penicillin		Sulfa Drugs		Aspirin		Codine
	Shellfish		Tape		Anaesthetic		Latex
	Antibiotics						

Other _____

Environmental Allergies: _____

Previous Injuries: Previous Surgeries: Previous Hospitalizations:

_____ _____ _____

_____ _____ _____

PATIENT HISTORY:

	Major Disease:		**RESPIRATORY:**		**VASCULAR:**		**Miscellaneous**
	Diabetes		Asthma		Anemia		Epilepsy
	Hypertension		Bronchitis		Sickle Cell		Thyroid Disease
	Angina		Frequent Colds		Bleeding Disorder		Muscle Disease
	Heart disease		Lung Disease		Poor Circulation		Kidney Problems
	Heart Attack		Shortness of Breath		Night Cramps		Prostate Problems
	Arrhythmia		Tuberculosis		Leg Pain if Walking		Venerial Disease
	Murmur		Emphysema		Vein Problems		Skin Condition
	Stroke				Spider Veins		Cancer History
	Chest Pain		**ARTHRITIS:**		Varicous Veins		Hepatitis
			Osteoarthritis		Swelling Problem		
	GASTROINTESTINAL:		Rheumatoid		Leg Ulceration		**Psychological:**
	Ulcers		Gout		Blood Clots		Anxiety
	Stomach Problem		Sero-negative		Transfusions		Depression
	Histal Hernia						Psychiatric Condition
	Bowel Disorder		**HEENT:**				Drug Dependence
	GI or Renal Bleeding		Headaches		Hospice		Alcohol Dependence
	Acid Reflux		Eye Problems				OTHER:
			Hearing Problems				

FAMILY HISTORY:

_____

SOCIAL HISTORY:__ Married __ Single __ Divorced __Widow
Occupation: _____
Athletic Activities: _____
Alcohol ___ oz/day __oz/week Tobacco ___ pks/day __yrs

PERMISSION TO TREAT

I hereby give my permission to Dr. Michael Lyons PC to advise treatment and to perform such procedures as may be deemed necessary in the diagnosis and/or treatment of the extremity condition. This treatment includes the dispensing of Durable Medical Equipment. I also hereby assign to the above named physician all benefits provided by my insurance company policy or policies for medical or surgical care. I understand that I am financially responsible for any balances on my account including any amount not covered by my insurance for DME. I understand that services and medical equipment is non-refundable.

_____ _____
Signature of Responsible Party Date

NOTICE OF PRIVACY PRACTICES
PATIENT ACKNOWLEDGEMENT

Patient Name: _____ DOB: _____

I have received this practice's Notice of Privacy Practices written in plain language. The Notice provides in detail the uses and disclosures of my protected health information that may be made by this practice, my individual rights, how I may exercise these rights, and the practice's legal duties with respect to my information.

I understand that this practice reserves the right to change the terms of its Notice of Privacy Practices, and to make changes regarding all protected health information resident at, or controlled by, this practice. I understand I can obtain this practice's current Notice of Privacy Practices on request.

Signature: _____

Date: _____

Relationship to Patient: _____

(Dear Patients: This Privacy Statement means that we have told you that your medical and personal information will not be given to anyone unless you allow us to do so. Please do so in writing. If you have any questions, please feel free to ask.)

PRIVATE INSURANCE POLICY HOLDERS

Dr. Michael Lyons PC has enrolled in numerous managed care insurance programs to accommodate the needs of our patients.

With each insurance program there are many individual requirements of the plans having different stipulations regarding what services are covered and how they may be performed. These plans differ depending on what type of contract your employer has negotiated.

Because we do not have access to each employer's guidelines and stipulations, we must rely on you, the patient, to inform us at the time of service exactly what those guidelines and stipulations are.

Unfortunately, if you do not inform us of special requirements in your insurance contract such as lab work, screening/preventive care, hospitalization, and/or out-patient procedures that are non-covered or must go to a specific location, previous DME received or the need for a referral from your primary care physician, we have no choice but to bill you directly for those charges. Payment for those charges is then your responsibility.

It is the patient's responsibility to keep our office up to date with their active insurance policy or any termination of insurance prior to each and every visit. Consequences of failing to do so lay fully on the patient.

Please check with your insurance if you have any questions relating to the services we provide. We want you to receive all of the benefits offered to you.

I HAVE READ AND UNDERSTAND THE OFFICE POLICY STATED ABOVE AND AGREE TO ACCEPT RESPONSIBILITY AS DESCRIBED.

_____ _____

Signature of Responsible Party Date

MEDICARE PATIENTS

I request that payment of authorized Medicare and/or insurance benefits be made on my behalf to Dr. Michael Lyons, PC for any services furnished me by said physician. I authorize any holder of medical information about me to release to the Health Care Financial Administration and its agents any information needed to determine the benefits payable to related services.

_____ _____

Cardholder Signature Date

Foot Health Centers

Michael Lyons, DPM	Robert Wenzler, DPM
P#662-449-3663	P#662-470-4608
F#662-449-3676	F#662-470-4610

Authorization for Use and Disclosure of Information

I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand this authorization is voluntary. I understand that information used or disclosed pursuant to the authorization may be disclosed by the recipient and may no longer be protected by the Federal Privacy Regulations.

Patient Name: _____

Person/Organization authorized to use or release the information: Foot Health Centers/Dr. Michael Lyons PC

Purpose of use or disclosure of health information: billing/continuity of care

I understand this authorization will expire: 1 year after above date

I understand that I may revoke this authorization at any time by notifying Foot Health Centers; however, if I revoke this authorization, my revocation is not effective to the extent Foot Health Centers has relied on this authorization before receiving my revocation.

I understand that Foot Health Centers/Dr. Michael Lyons PC will not condition my treatment, payment or enrollment in a health plan on whether I provide authorization for the use and disclosure described above except:

-If my treatment is related to research

-If healthcare is provided to me solely for the purpose of creating protected health information for disclosure to a third party

Patient's signature: _____ Date: _____

OR Patients representative: _____

Relationship to patient: _____

Office Manager

662-449-3663

Foothealthbilling@gmail.com