Alexis Lund, DPM, D.ABFAS
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Hockessin, DE 19707
P: 302-239-1625 | F: 302-239-1626

Patient Name: _____ Date of Birth: _____

Male ⬜ Female ⬜ SSN: _____ ⬜ Decline to disclose SSN

Address: _____

Home Phone: _____ Cell Phone: _____

Emergency Contact: _____ Relation: _____

Phone: _____

Family Physician: _____ Phone: _____

Pharmacy Name: _____

Address: _____

Phone: _____

Person responsible for payment: _____

Insurance Company: _____ Subscriber Name: _____

Subscriber DOB: _____ ID Number: _____

Secondary Insurance: _____ ID Number: _____

MEDICAL HISTORY

Do you smoke or use tobacco products? _____ Packs per day _____ Years _____

Do you drink alcohol? _____ Drinks per day _____ Females: Are you pregnant? _____

Allergies: *If none, please write "None."* _____

Height: _____ Weight: _____ Shoe size: _____

Please check if you have or have had any of the following:

- ⬜ High blood pressure
- ⬜ Heart disease
- ⬜ Heart murmur
- ⬜ Stroke
- ⬜ Seizures
- ⬜ Diabetes
- ⬜ Chronic bronchitis
- ⬜ Asthma
- ⬜ **No medical history reported**
- ⬜ Tuberculosis
- ⬜ Sleep apnea
- ⬜ Kidney disease
- ⬜ Sickle cell/trait
- ⬜ Lupus
- ⬜ High cholesterol
- ⬜ Cancer: _____
- ⬜ Gout
- ⬜ Other: _____
- ⬜ AIDS
- ⬜ HIV
- ⬜ Osteoporosis
- ⬜ COPD
- ⬜ Arthritis
- ⬜ Thyroid disorder
- ⬜ Hepatitis ⬜ A ⬜ B ⬜ C
- ⬜ Emphysema

Current Medications: _____

_____

⬜ **No medications reported**

DIABETICS ⬜ Type I ⬜ Type II

Most recent HbA1c and approximate date: _____

Managing physician and date of last visit: _____

FAMILY HISTORY ⬜ **No family history reported**

Mother: ⬜ Hypertension ⬜ Diabetes ⬜ Stroke ⬜ Heart disease ⬜ Other: _____

Father: ⬜ Hypertension ⬜ Diabetes ⬜ Stroke ⬜ Heart disease ⬜ Other: _____

SURGICAL HISTORY ⬜ **No surgical history reported**

- ⬜ Tonsillectomy
- ⬜ Hernia repair
- ⬜ C-section
- ⬜ Appendectomy
- ⬜ CABG
- ⬜ Tubal ligation
- ⬜ LE bypass surgery
- ⬜ Hysterectomy
- ⬜ Cholecystectomy
- ⬜ Mastectomy
- ⬜ Breast lumpectomy
- ⬜ Foot amputation
- ⬜ Other: _____

REQUEST FOR SIGNATURE ON FILE:

Below is a request to put your signature on file permanently in our office. This means that by signing below, you will not have to sign the release of medical information or release of payment directly to the doctor each time that you come into our office. By doing this, you will be helping us process your insurance claims faster and more efficiently. If you have any further questions about this, please ask our receptionist.

- I authorize the use of this form on all my insurance submissions.
- I authorize the release of information to all my insurance companies.
- I understand that I am responsible for my bill.
- I understand that I have an agreement with my insurance company and that it is my duty, not the physician's duty, to resolve issues of non-payment. I also understand that my insurance company may not cover medications, medical services, or medical goods that may be prescribed by my physician. Once again, issues of payment are based on an agreement between myself and my insurance company, not the physician.
- I authorize the submitting of a claim for services to my insurance company.
- I authorize payment directly to my physician.
- I permit a copy of this authorization to be used in place of the original.
- I authorize the sending of lab specimens to the laboratory.

OFFICE POLICIES

- When appointments are not canceled within 24 hours of the appointment time, you will incur a **$50.00 no show fee**.
- Refills may take up to 72 hours following a request to be processed correctly. Also, if you have not seen the physician in over one month, an appointment may be required prior to filling a script.
- You are required to have referrals completed before seeing the physician. For questions about whether a referral is necessary, please contact your insurance provider.
- If you have Medicare, routine foot care (nail and callus trimming) may not be covered. A waiver must be signed before seeing the physician. If routine foot care is not covered, payment is due at the time of service.
- Services or products which are not covered by your insurance company are to be paid at the time of service/dispensing of the product.
- The physician reserves the right to bill patients directly if his/her insurance company has not paid the physician in a timely fashion (30 days). Patients are expected to call their insurance company to resolve issues of non-payment before the service or item will be re-billed.

Patient Name Printed: _____

Patient/Representative Signature: _____ Date: _____

HIPAA PATIENT PRIVACY DATA RELEASE & CONSENT FORM

HIPAA, the Health Insurance Portability and Accountability Act, requires that all medical providers, insurance companies, and others put in place controls to ensure that your personal medical information and privacy data are secured. Lund Podiatry, LLC requests that each patient signs this patient privacy data release and consent form which allows us to share your personal health information (PHI) or electronic protected health information (ePHI) with other medical service providers and specialists as needed to perform your healthcare services.

Release & Assignment

I hereby authorize Lund Podiatry, LLC to release my protected health information to my insurance company, which may include my diagnosis, treatment, and demographic information. I hereby sign to the above all payments for medical services rendered to my dependent or myself. I understand that I am responsible for any amount not covered by insurance. I understand that if any unpaid balance is sent to a collective agency, I will incur a service fee. I consent to treatment of my condition as indicated by my medical history and the physician's diagnosis.

Verbal & Written Communication

Many of our patients allow family members, such as a spouse or parent, to call and request information over the phone or pick up written medical information. This information includes tests, results of procedures, and medical history. Under the requirements of HIPAA, we are not allowed to give information to anyone without a patient's written consent. You have the right to revoke consent in writing, except where we have already made disclosures based on your prior consent. This will remain in force until revoked or requested in writing by you. I authorize Lund Podiatry, LLC to release all medical information over the phone and in writing about my care to the individuals listed below (this information includes but is not limited to test results, procedure results, medical history, etc.). **If you wish to have your protected health information released to family members you must review, fill in, and sign this form. Automatic "OPT OUT" if you do not list any individuals below; our office will not release verbal or written communication to anyone other than you, the patient.**

1. _____ Relation to patient: _____

2. _____ Relation to patient: _____

3. _____ Relation to patient: _____

4. _____ Relation to patient: _____

Preferred Mailing/Email Communication

Lund Podiatry, LLC mails/emails patients many different reminders as well as hard copies of reports, per patient request. We ask that you list your current mailing address and email so that we can send you announcements and reminders when due for appointments, labs, etc. If you update your address with the office verbally, in writing, or online, it will override the below addresses and still allow our office to mail medical information.

Mailing address: _____

_____

Email address: _____

Preferred Phone Communication

Please list all phone numbers you prefer for all personal healthcare communications with Lund Podiatry, LLC. If you receive your voicemail, our office will leave detailed medical information. If you update your phone number verbally, in writing, or online, it will override the below phone numbers and still allow our office to leave detailed messages. You have the right to revoke this consent, in writing, except where we have already made disclosures based on your prior consent. This consent will remain in force until revoked.

Home: _(_____)_____

Cell: _(_____)_____

Work: _(_____)_____

Other: _(_____)_____

☐ **Check this box if you choose to "OPT OUT" from receiving detailed voicemails, documentation, or reports via phone, address, or email.**

(Note: If you "OPT OUT," our office will still contact you by phone leaving a general voicemail for you to contact our office and will still mail/email posts with any office updates.)

Receipt & Acknowledgement

By signing and dating below, you acknowledge receipt of Lund Podiatry, LLC and OMNIBUS Updated Patient Privacy Data Release & Consent Form and have reviewed these practices and procedures and fully understand them. It is your right to request a hard copy from Lund Podiatry, LLC.

Patient Name: _____ DOB: _____

Signature of Patient/Representative: _____ Date: _____

DO I NEED A TEST FOR PERIPHERAL ARTERY DISEASE (PAD)?

Name: _____ Date: _____

PAD is a serious circulatory problem in which the blood vessels that carry blood to your arms, legs, brain, and kidneys become narrowed and clogged. It affects over 8 million Americans, most over the age of 50. It may result in leg discomfort with walking, poor healing of leg sores/ulcers, blood pressure that is difficult to control, or symptoms of stroke. People with PAD are at significantly higher risk of stroke and heart attack. Answers to these questions will help determine if you are at risk for PAD and if a vascular exam will help us better assess your vascular health status.

Check all applicable boxes:

⬜ Do you have foot, calf, buttock, hip, or thigh discomfort (aching, fatigue, tingling, cramping, or pain) when you walk, which is relieved by rest?

⬜ Do you have a history of cardiovascular disease or diabetes and experience pain or swelling at rest in your lower legs or feet?

⬜ Do you have a history of cardiovascular disease or diabetes and experience any leg, foot, or toe pain that disturb your sleep?

⬜ Do you have an ulcer on your thigh, calf, ankle, foot, or toe that is slow to heal?

⬜ Do you have diabetes and unusual hair loss or skin discoloration on your legs?

⬜ Do your fingers or toes feel numb or cold in response to temperature changes or stress?

⬜ Have you suffered a severe injury to your leg(s) or feet?

⬜ Do you have an infection of the leg(s) or feet that may be gangrenous (black skin tissue)?

⬜ Have you had blockages in your coronary or heart arteries?

Other comments: _____

_____