ATLANTIC PODIATRY

PATIENT INFORMATION FORM

(PLEASE PRINT)

DATE: ___/____/____

PATIENT NAME: _______________ _______________ ___ DATE OF BIRTH: ___/___/___ AGE: ___ SEX: M F
LAST FIRST MI

HOME ADDRESS: __________________________________ CITY/STATE: _____________________ ZIP: ___________

MAY WE LEAVE A MESSAGE?

HOME PHONE #: (____) ____-_______ YES NO

CELL PHONE #: (____) ____-_______ YES NO TEXT APPOINTMENT REMINDER YES NO

E-MAIL: _________________________________ YES NO

PRIMARY LANGUAGE: _______________________

DO YOU HAVE A LEGAL GUARDIAN OR HEALTHCARE POWER OF ATTORNEY? YES NO

IF YES, NAME: _________________________ RELATIONSHIP: ___________ PHONE #: (____) ____-______

EMERGENCY CONTACT: _________________________ RELATIONSHIP: ___________ PHONE #: (____) ____-______

PRIMARY CARE DOCTOR: _____________________ WHO REFERRED YOU TO US? ______________________________

PHARMACY: __________________________ LOCATION: _______________________ PHONE #: (____) ____-______

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

_____ YES NAME(S) ____

_____ NO

WHO IS RESPONSIBLE FOR PAYMENT? ___________________________ RELATIONSHIP TO PATIENT? ______________

ADDRESS: _____________________ CITY/STATE: _______________ ZIP: ________ PHONE #: (____) ____-_____

INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY NAME: ____

SECONDARY INSURANCE COMPANY NAME: ____

IF SUBMITTING IN ADVANCE PLEASE INCLUDE COPIES FRONT AND BACK OF INSURANCE CARD TO EXPEDITE YOUR VISIT

PATIENT NAME: ______________________________
DATE OF BIRTH: ____/____/_____

PLEASE LIST ALL PRIOR SURGERIES:

TYPE OF SURGERY	DATE	TYPE OF SURGERY	DATE

PLEASE LIST ALL PRIOR HOSPITALIZATIONS (OTHER THAN FOR SURGERY):

REASON FOR HOSPITALIZATION	DATE	REASON FOR HOSPITALIZATION	DATE

SOCIAL HISTORY

MARITAL STATUS: ☐ SINGLE ☐ MARRIED ☐ PARTNERED ☐ SEPARATED ☐ DIVORCED ☐ WIDOWED

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 ☐ MODERATE ☐ DAILY

EMPLOYER: _____________________________________ OCCUPATION: ____

HOW MUCH ARE YOU ON YOUR FEET AT WORK? ☐ 10% ☐ 25% ☐ 50% ☐ 75% ☐ 100%

DO OTHERS DEPEND UPON YOU FOR THEIR CARE? ☐ CHILDREN–AGE(S) ______ ☐ PET(S)–WHAT KIND? _______
☐ ELDERLY OR DISABLED FAMILY MEMBER ☐ OTHER ____

EXERCISE: ☐ NEVER ☐ RARE ☐ OCCASIONAL ☐ WEEKLY ☐ SEVERAL TIMES A WEEK ☐ DAILY

TYPES OF EXERCISE: ____

FAMILY HISTORY

DO YOU HAVE A FAMILY HISTORY OF: ☐ DIABETES ☐ CANCER ☐ HEART DISEASE ☐ HIGH BLOOD PRESSURE
☐ STROKE ☐ CORONARY ARTERY DISEASE ☐ THYROID DISEASE ☐ RHEUMATOID ARTHRITIS
☐ OTHER ____

MEDICATIONS: Prescription and nonprescription medicines, include herbal medications or Attach list
.

NAME	DOSE	HOW OFTEN DO YOU TAKE?

PATIENT NAME: ______________________________
DATE OF BIRTH: ____/____/_____

HAVE YOU HAD:

Problems with your heart ? (check all that apply)
__Blood pressure or related problems 401.9
__ Heart Attack (MI) 410.9
__ Angina 413.9
__ Congestive Heart Failure 428.0
__ Arrhythmia (irregular heart beat) 427.8
__ Coronary artery disease 411.89
__ Peripheral vascular disease (poor circulation) 440.2
__ Blood clot in leg (DVT) 454.1
__ High Cholesterol 272.4
__ Other____________________________________

Problems with your skin ? (check all that apply)
__ Cellulites (skin infection) 682.9
__ Psoriasis 696
__ Skin Cancer 173
__ Excessive scarring 709.2
__ Shingles (zoster) 053
__ Chronic recurrent athletes foot (tinea pedis) 110.9
__ Thick or discolored nails 757.5
__ Other____________________________________

Endocrine Problems ? (check all that apply)
__ Diabetes 250
__ Hypothyroid (low thyroid -- common) 244.9
__ Hyperthyroid (high thyroid—less common) 242.90
__ Other______________________________

Genetic/Congenital disorders ? (check all that apply
__ Trisomy 21 (down syndrome) 758.0
__ Learning disabilities 315.2
__ Sickle cell 282.60
__ Other____________________________________

Gastrointestinal Problems ? (check all that apply)
__ Reflux (GERD) 530.81
__ Peptic Ulcer disease 533
__ Liver disease (type______________________) 575.
__ Cholecystitis (gallblader disease) 575.1
__ Diverticulits 562
__ Colon cancer 153.9
__ Other____________________________________

Problems with your eyes, ears, nose, throat
__ Glaucoma 365.9
__ blindness 369.00
__ deafness 389.9
__ vertigo 438.85
__ Macular Degeneration 362.5
__ Other____________________________________

Problems with your lungs ? (check all that apply)
__Asthma 493
__ COPD 496
__ Emphysema 492
__ Sleep apnea 327.23
__Chronic bronchitis 490
__ Lung cancer 165.9
__ Pneumonia 486
__ Other__________________________________

Problems with your blood or kidneys? (check all that apply)
__ Anemia 285.9
__ Difficulty stopping bleeding 286
__ Use of blood thinners 286.7
__ lymphoma 202
__ Kidney disease 585
__ Dialysis 585.6

Problems with your Immune System
__ Organ Transplant (Specify_______________) v45.87
__ Lupus 695.4
__ anaphylactic reaction (to what______________)v49.0
__ HIV/AIDS 042
__ Other________________________________

Musculoskeletal Problems ? (check all that apply)
__ Osteoarthritis (degenerative joint disease) 715
__ Rheumatoid arthritis 714.0
__ other arthritis (Specify____________________)
__ Gout 274.9
__ Spinal stenosis 724.0
__ Sciatica 724.3
__ Herniated disks (back or neck) 722.6
__ Amputation (specify___________________)v49.0
__ Osteoporosis 733
__ Fibromyalgia 729.1
__ Other____________________________________

Psychiatric Problems ? (check all that apply)
__ Depression 311
__ Anxiety 300.00
__ Substance abuse __current __ recovery 304.9
__ Alcohol Abuse __current __ recovery 303.9
__ other___________________________________

Neurological Problems ? (check all that apply)
__ Neuropathy 356.4
__ stroke 436
__ TIA 435.9
__ Dementia 290
__ Multiple sclerosis 340
__ Migraines 346
__ Parkinson's disease 322
__ seizure disorders 345
__ Other__________________________________

Have you ever received <u>general</u> anesthesia? YES NO
Have you ever had any adverse reaction to local or general anesthesia? Y N
Do you have any other Medical problems ? YES NO

IF yes or any other information you think may be important____
____
____

Do you have Primary care doctor? Yes NO
Who_____________________________
Would you object to having us send a copy of our notes to your doctor for his /her chart? YES NO

PATIENT NAME: ______________________________
DATE OF BIRTH: ____/____/_____

REVIEW OF SYMPTOMS: Please check any current symptoms you have.

Constitutional
___Recent fevers/sweats
___Unexplained weight gain
___Unexplained weight loss
___Unexplained Fatigue

Respiratory
___Cough
___Wheeze
___Shortness of breath

Skin
___Rash
___New or change in mole
___Open wound or sore
Where___________________

Eyes
___Blurred vision
___Change in vision
___Red eyes

Gastrointestinal
___Heartburn/reflux
___Blood or change in bowel . movement
___Nausea/vomiting/diarrhea
___Pain in abdomen

Neurological
___Headaches
___Memory loss
___Fainting
___ Numbness in feet

Ears/Nose/Throat/Mouth
___Hay fever
___Allergies
___Congestion
___Trouble swallowing
___Difficulty hearing
___Ringing in ears

Genitourinary
___Night time urinary frequency
___Painful/bloody urination

Psychiatric
___Anxiety/stress
___Sleep problem
___ Depression

Cardiovascular
___Chest pain___pressure
___Palpitations
___Short of breath with exertion

Trauma
___ recent fall
___ recent Motor vehicle crash

Blood/Lymphatic
___Unexplained lumps
___Easy bruising
___bleeding

Musculoskeletal
___Muscle/joint swelling
where ____________________
___Muscle/joint pain
*Where*____________________
___Recent back pain

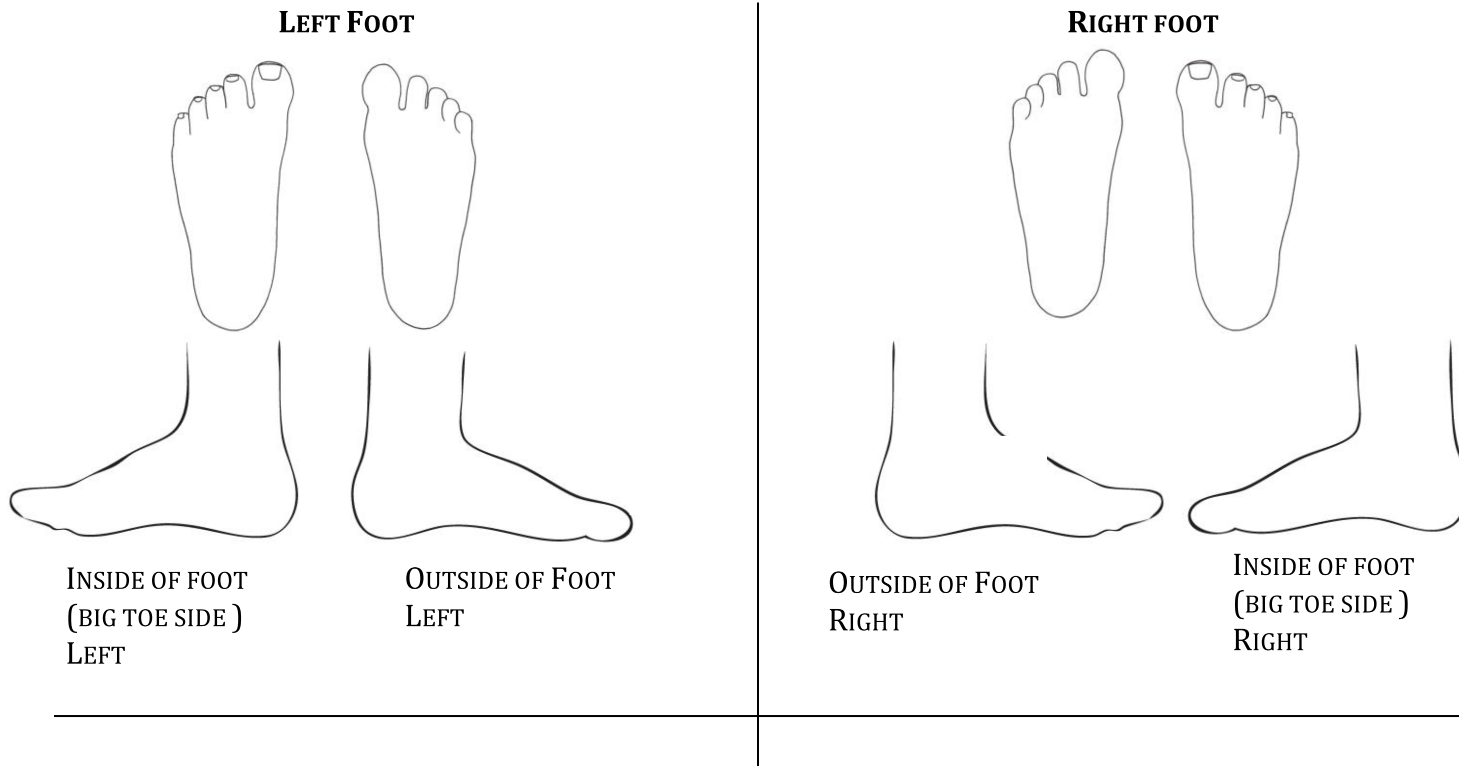
Endocrine
___Cold intolerance
___heat intolerance
___Increased thirst
___ increased appetite
___recent high blood sugar
___low blood sugar

Patient Name: ________________________________
Date of Birth: ____/____/_____

Current Problem

What specific problem brings you to our office today? ____

Where is the pain/problem located? Please mark on the pictures below.



How long ago did this problem first start? _________ Days / Weeks / Months / Years

Did your pain or problem: ☐ Begin all of a sudden ☐ Gradually develop over time

How would you describe your pain? ☐ No pain ☐ Sharp ☐ Dull ☐ Aching ☐ Burning ☐ Radiating ☐ Itching ☐ Stabbing ☐ Other ____

How would you rate your pain on a scale from 0 to 10? (please circle)

(no pain) 0 1 2 3 4 5 6 7 8 9 10 *(worst pain possible)*

Since the time your pain or problem began, has it: ☐ stayed the same ☐ become worse ☐ Improved

What makes your pain or problem feel worse? ☐ Walking ☐ Standing ☐ Daily activities ☐ Resting ☐ Dress shoes ☐ High heels ☐ Flat shoes ☐ Any closed toe shoe ☐ Running ☐ Other ____

What makes your pain or problem feel better? ____

What treatments have you had for this problem? ____

How has this problem affected your lifestyle or ability to work? ________________________________

Was this problem caused by an injury? ☐ Yes (describe) ________________________________ ☐ No

If yes, was it a work-related injury? ☐ Yes ☐ No

PATIENT NAME: ________________________________
DATE OF BIRTH: ____/____/_____

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 OF DOCTOR

____
IF OTHER THAN PATIENT, RELATIONSHIP TO PATIENT

____
DATE

____
SIGNATURE

____
DATE

PATIENT NAME: ______________________________
DATE OF BIRTH: ____/____/_____

CONSENT TO TREATMENT

I hereby consent to and authorize the performance of all appropriate procedures and courses of treatment, the administration of all anesthetic, and any and all medication or technical procedures which in the judgment of the physician(s) may be considered necessary or advisable for the diagnosing or treating of my condition.

ASSIGNMENT OF INSURANCE BENEFITS

I authorize payment of insurance benefits directly to *Atlantic Podiatry Centers*. Where MEDICARE BEEFITS are applicable, I certify that the information given by me in applying for payment under Title XVIII or XIX of the Social Security Act is correct and request that the payment of authorized benefits be made on my behalf.

GUARANTEE OF PAYMENT

For services rendered, I guarantee payment of any and all charges incurred which are not covered or allowed by my insurance or Medicare. I also understand that I am fully responsible for any denial of payment due to lack of medical necessity or pre-certification or constraint imposed as a condition of my insurance coverage. It is further agreed that if this account be referred for collection, I will pay the costs relating to any and all collection efforts.

NON COVERED MEDICAL SUPPLIES

From time to time, your treating physician may find it necessary to recommend medical supplies to aid in the treatment of your condition. These supplies are not covered by your insurance company. Payment will be expected at the time of service. If you do not wish to purchase a recommended supply, please notify the Doctor or Nurse of your decision.

CONSENT FOR BASIC USE OF YOUR PROTECTED HEATLH INFORMATION

I hereby give my consent for Atlantic Podiatry Centers to use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). This includes but is not limited to: (1)The practice may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance issues and any calls pertaining to my clinical care, including laboratory results among others. (2) The practice may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as patient statements as long as they are marked Personal and Confidential. *For a complete description of such uses and disclosures please refer to our Notice of Privacy Practices.*

By signing this form, I am consenting to Atlantic Podiatry Centers use and disclosure of PHI to carry out TPO.I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Atlantic Podiatry Centers may decline to provide treatment to me.

** In addition to myself, details of my care may be discussed with the following family member or caretaker.

ī **NONE** ī

_______________________________ _____________________   _______________________________ _____________________

Family member/caretaker's Name Relationship   Family member/caretaker's Name Relationship

i HAVE READ AND UNDERSTAND THE ABOVE STATEMENTS

___________________________________/__/20___   ____________________________________

Signature of Patient or Legal Guardian Date   Printed Name of Patient or Legal Guardian

PATIENT NAME: ______________________________
DATE OF BIRTH: ____/____/_____

ACKNOWLEDGMENT OF RECEIPT OF
NOTICE OF PRIVACY PRACTICES

I ACKNOWLEDGE THAT I WAS PROVIDED A COPY OF THE NOTICE OF PRIVACY PRACTICES AND THAT I HAVE READ (OR HAD THE OPPORTUNITY TO READ IF I SO CHOSE) AND UNDERSTOOD THE NOTICE.

PATIENT NAME (PLEASE PRINT)

____

DATE

____

PARENT OR AUTHORIZED REPRESENTATIVE (IF APPLICABLE)

____

SIGNATURE

____