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 USING THE FOLLOWING ?
HOME PHONE #: (____) ____-_____ YES NO

CELL PHONE #: (____) ____-_____ YES NO TEXT APPOINTMENT REMINDER YES NO
E-MAIL: _____ YES NO

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: _____

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 #: (____) ____-_____

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

HEADER

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

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 _____

ALLERGIES:

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

NAME	DOSE	HOW OFTEN DO YOU TAKE?

HAVE YOU HAD:

Problems with your heart ? (check all that apply)
- __Blood pressure or related problems I 10
- __ Heart Attack (MI) I 21.3
- __ Angina I 20.9
- __ Congestive Heart Failure I 50.9
- __ Arrhythmia (irregular heart beat) I 49.8
- __ Coronary artery disease I 24.9
- __ Peripheral vascular disease (poor circulation) I 70.209
- __ Blood clot in leg (DVT) I 83.10
- __ High Cholesterol E 78.5
- __ Other_____

Problems with your skin ? (check all that apply)
- __ Cellulites (skin infection) L03.90
- __ Psoriasis L40.9
- __ Skin Cancer C44.701
- __ Excessive scarring L 90.5
- __ Shingles (zoster) B02
- __ Chronic recurrent athletes foot (tinea pedis) B35.9
- __ Thick or discolored nails Q 84.3
- __ Other_____

Endocrine Problems ? (check all that apply)
- __ Diabetes E 11.42
- __ Hypothyroid (low thyroid -- common) E03.9
- __ Hyperthyroid (high thyroid—less common) E05.90
- __ Other_____

Genetic/Congenital disorders ? (check all that apply
- __ Trisomy 21 (down syndrome) Q 90.9
- __ Learning disabilities F 81.89
- __ Sickle cell D 57.1
- __ Other_____

Gastrointestinal Problems ? (check all that apply)
- __ Reflux (GERD) K 21.9
- __ Peptic Ulcer disease K 27.3
- __ Liver disease (type_____ K 76.9
- __ Cholecystitis (gallbladder disease)
- __ Diverticulits K 57.92
- __ Colon cancer C 18.9
- __ Other_____

Problems with your eyes, ears, nose, throat
- __ Glaucoma H 40.9
- __ blindness H 54.0
- __ deafness H 91.90
- __ vertigo H 81.4
- __ Macular Degeneration
- __ Other_____

Problems with your lungs ? (check all that apply)
- __Asthma J 45.30
- __ COPD J 44.9
- __ Emphysema J 43.9
- __ Sleep apnea G 47.33
- __Chronic bronchitis J 40
- __ Lung cancer C 39.9
- __ Pneumonia J 18.9
- __ Other_____

Problems with your **blood or kidneys?** (check all that apply)
- __ Anemia D 64.9
- __ Difficulty stopping bleeding D68.9
- __ Use of blood thinners D 68.4
- __ lymphoma C 82
- __ Kidney disease N 18.1
- __ Dialysis N 18.6

Problems with your **Immune System**
- __ Organ Transplant (Specify_____ Z 98.85
- __ Lupus L 93.2
- __ anaphylactic reaction (to what_____ T 78.2
- __ HIV/AIDS B 20
- __ Other_____

Musculoskeletal Problems ? (check all that apply)
- __ Osteoarthritis (degenerative joint disease) M 19.1
- __ Rheumatoid arthritis M 05.9
- __ other arthritis (Specify_____)
- __ Gout M 10.9
- __ Spinal stenosis M 48.0
- __ Sciatica M 54.30
- __ Herniated disks (back or neck) M 51.36
- __ Amputation (specify_____ Y 83.5
- __ Osteoporosis M 81.0
- __ Fibromyalgia M 60.80
- __ Other_____

Psychiatric Problems ? (check all that apply)
- __ Depression F 32.9
- __ Anxiety F 41.1
- __ Substance abuse __current __ recovery F 19.20
- __ Alcohol Abuse __current __ recovery F 10.20
- __ other_____

Neurological Problems ? (check all that apply)
- __ Neuropathy G 60.3
- __ stroke I 67.89
- __ TIA G 45.9
- __ Dementia F03.90
- __ Multiple sclerosis G 35
- __ Migraines G 43.0
- __ Parkinson's disease G 20
- __ seizure disorders F 44.5
- __ Other_____

Do you have any other Medical problems ? YES NO
please list _____

Is there any other information you think may be important_____

REVIEW OF SYMPTOMS: Please check any <u>current</u> symptoms you have.

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

Eyes
___Blurred vision
___Change in vision

___Red eyes

Ears/Nose/Throat/Mouth

___Hay fever
___Allergies
___Congestion
___Trouble swallowing

___Difficulty hearing
___Ringing in ears

Cardiovascular
___Chest pain___pressure

___Palpitations

___Short of breath with exertion

Respiratory
___Cough
___Wheeze

___Shortness of breath

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

Genitourinary
___Night time urinary frequency

___Painful/bloody urination

Trauma
___ recent fall

___ recent Motor vehicle crash

Musculoskeletal

___Muscle/joint swelling
where _____
___Muscle/joint pain
*Where*_____
___Recent back pain

Skin
___Rash
___New or change in mole

___Open wound or sore
Where_____

Neurological
___Headaches
___Memory loss

___Fainting
___ Numbness in feet

Psychiatric
___Anxiety/stress

___Sleep problem

___ Depression

Blood/Lymphatic
___Unexplained lumps

___Easy bruising
___bleeding

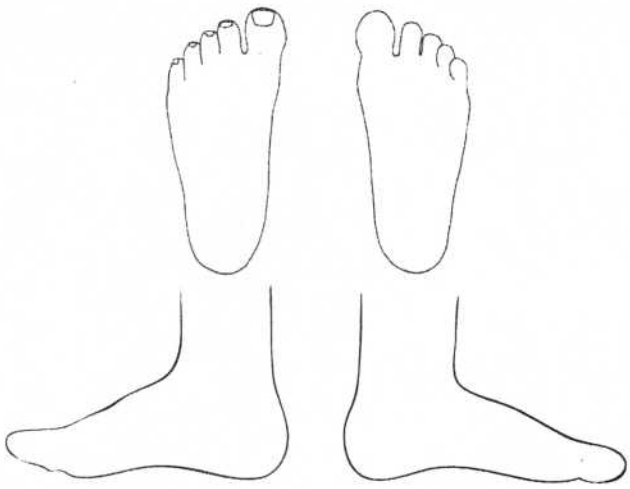
Endocrine
___Cold intolerance
___heat intolerance
___Increased thirst
___ increased appetite
___recent high blood sugar
___low blood sugar

CURRENT PROBLEM

WHAT SPECIFIC PROBLEM BRINGS YOU TO OUR OFFICE TODAY? _____

WHERE IS THE PAIN/PROBLEM LOCATED? PLEASE MARK ON THE PICTURES BELOW.

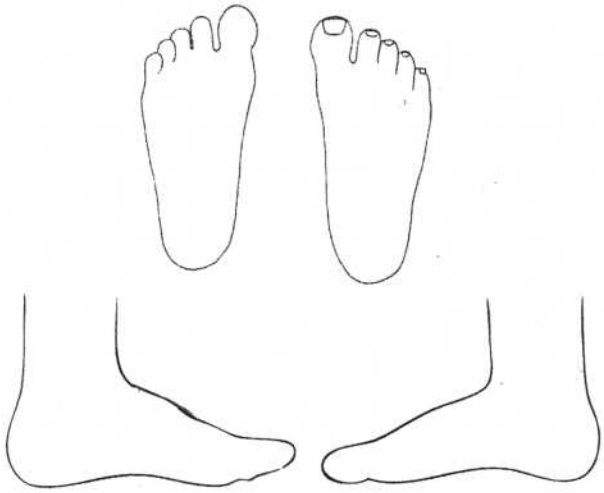
LEFT FOOT



INSIDE OF FOOT (BIG TOE SIDE) LEFT

OUTSIDE OF FOOT LEFT

RIGHT FOOT



OUTSIDE OF FOOT RIGHT

INSIDE OF FOOT (BIG TOE SIDE) RIGHT

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

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

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

Consent for Photography, Videotaping, or Other Imaging for Media or Educational Purposes

Patient's Name: _____ Patient's Date of Birth: _____

"I understand that photographs, videotapes, digital, or other images may be recorded to document my care, and I consent to this. I understand Atlantic Podiatry will retain ownership rights to these photographs, videotapes, digital, or other images, but that I will be allowed access to view them or obtain copies. I understand that these images will be stored in a secure manner that will protect my privacy and that they will be kept for the time period required by law or outlined in Atlantic Podiaty's policy. Images that identify me will be released and/or used outside the institution only upon additional written authorization from me or my legal representative."

I give my consent to have photographs, videotaped images, or other images made of __myself__ or_____. I understand and agree that these images may be used by Atlantic Podiatry for the purpose outlined below.

__x___ as part of my medical record and as needed for billing my insurance

_____ Teaching purposes, (Our Doctor from time to time do lectures for medical students, other physicians, nurses, and patient support groups).*

*Personally identifiable features (face or unique tattoos) will be removed or obscured no name initials etc. will be included for these purposes without additional consent.

_____ _____

Signature of patient/legal representative If legal representative, relationship to patient

_____

Date

_____ _____

Signature of witness Date

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.

T NONE T

_____ _____ _____ _____

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

CONSENT FOR TRANSFER OF BIOLOGICAL SPECIMEN

Florida law (Section 817.5655, Florida Statutes) prohibits the sale or transfer of a person's biological specimen from which DNA can be extracted to a third party without the express consent of such person. This law applies even when the biologic specimen is not taken for the purpose of DNA analysis or is not purposefully taken (such as a drop of blood on a band aid or a used tissue)

During the course of your care at Atlantic Podiatry, it may be medically necessary to obtain a blood, urine, stool, tissue or other type of biological specimen for analysis. This specimen will typically be transferred to an independent laboratory for analysis. **This analysis <u>will NOT</u> involve the examination of your DNA to identify the presence and composition of genes in your body.**

After the analysis has been performed and the sample is no longer needed, it will be stored as medical waste and then transferred to a third party for disposal in accordance with all local, state and federal requirements. It may also be the case that a biological specimen (such as blood, urine, hair, bodily fluids, etc.) from you may be deposited on medical instruments, bedding, clothing or other objects. These objects may then be transferred to a third party for cleaning or disposal. By signing this document, you affirmatively state that it is your intentional decision to consent to the transfer of any and all biological specimens collected by or deposited with Atlantic Podiatry to a third party as set forth above. This consent does not authorize the sale or transfer of a biological specimen for the purpose of DNA analysis.

_____

Signature of Patient (or Proxy)

_____

Printed Name of Patient

_____

Date