Affiliated Podiatry Group

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Patient Information

Patient Name: First_____ Middle Initial ____ Last _____
Mail Address_____Apt#_____ City_____ State____ Zip_____
Home Phone_____ Cell Phone_____ Birth Date_____
Age_____ Sex_____ Marital Status_____ Social Security Number_____
Responsible Party_____
Email address_____

☐ **Information has not changed since last time filling out a patient information sheet.**

Primary Insurance

Primary Insurance Company_____
Insured's Name_____ SS#_____Birth Date_____
Insured's
Employer_____ID#_____Group#_____

Secondary Insurance

Secondary Insurance
Company_____
Insured's Name_____ SS#_____Birth Date_____
Insured's Employer_____ ID#_____Group#_____

**Primary Care Physician_____ Phone: _____Fax: _____

Are you currently pregnant? No _____ Yes_____ How many weeks _____

Please mark to indicate if you have had any of the following problems:

___ **Diabetes**
___ Allergies/Hay fever
___ Anemia
___ Arthritis
___ Asthma
___ Bleeding Tendency
___ Chest Pain
___ Circulation Problems
___ Fainting or Convulsions
___ Gout
___ Headaches
___ Heart Disorders
___ High Blood Pressure
___ HIV
___ Joint Pain / Stiffness
___ Kidney Disorders
___ Leg Pain
___ Liver Disease/Jaundice
___ Lower Back Pain
___ Lung Disorder
___ Numbness in feet / legs
___ Psychiatric Disorders
___ Recent Weight Loss
___ Scaring Tendency
___ Shortness of breath
___ Skin Disorders
___ Stomach Disorders
___ Strokes
___ Swelling in feet/ankles
___ Thyroid Disorders
___ Trouble with hearing
___ Trouble with vision
___ Other _____
___ **None of the above**

***PLEASE FILL OUT BACK OF THIS SHEET

Medical History

Are you **ALLERGIC** to any medications? No _____ Yes _____
If so, please list _____
_____

Social History

Do you smoke? No____ Yes ____ (please circle) (every day some days former)
Do you drink alcohol? No___ Yes___ (please circle) (mild moderate everyday before bedtime)
Race: (Please circle) Caucasian African American Hispanic Asian Other:_____
Preferred Language (Please circle) English Spanish Other: _____
Have you ever used any illegal drugs (No Yes) If so which ones _____

Family History

Indicate which of your immediate relatives have had any of the following diseases:
Cancer_____ Diabetes_____ Heart Trouble_____
High Blood Pressure_____Kidney Disease_____
Mental/ Emotional Disease_____ Stroke_____ Arthritis_____

Consent For Treatment

I agree to pay for all services at the time they are rendered, unless other arrangements have been made. I furthermore give my consent to Affiliated Podiatry to bill my insurance company and for them to be paid directly for services rendered. I understand that my agreement with the insurance company is between me and the insurance company and that my doctor will bill them as a courtesy to me. I understand that I will be held liable for all copay, deductible, and coinsurance amounts. I further understand that I am responsible for any unpaid balance on my account. **I also understand that it is my responsibility to ensure that the doctor I see is a provider for my insurance and that I can be held responsible if he is not.** If collection fees are required, I agree to pay all legal and collection fees which are incurred. I hereby give my permission to Affiliated Podiatry to administer treatment and to perform minor operative procedures as may be deemed necessary in the diagnosis and treatment of my foot condition.

Signed_____ Witness_____
Patient Signature
Date_____

HIPAA Privacy Policy

I acknowledge that I have read and understand Affiliated Podiatry's "Access Authorization Policy". I further understand that I may receive my own copy upon my request.

Signed_____ Witness_____
Patient Signature
Date_____

CONSENT TO DISCUSS PATIENT INFORMATION

Federal Regulation defined under the Health Insurance Portability and Accountability Act (HIPAA), as amended, does not allow the physicians or their staffs to release, discuss, or otherwise disclose protected patient information without the express written consent of you, the Patient. If you would like this office to be able to discuss your medical care with someone other than yourself, please list the names of the individuals below. Persons on this list must provide their own identification and be able to verify your date of birth as a measure of added security before the release of any information.

PLEASE NOTE: YOUR SPOUSE AND/OR CHILDREN ARE NOT AUTOMATICALLY ALLOWED ACCESS TO YOUR RECORDS UPON REQUEST WITHOUT A WRITTEN POWER OF ATTORNEY OR WITH A COURT ORDER DECLARING THE PATIENT INCOMPETENT TO MAKE MEDICAL DECISIONS.

NAME OF PERSON ALLOWED ACCESS	RELATIONSHIP TO PATIENT
1._____	_____
2._____	_____
3._____	_____
4._____	_____

_____ _____

Patient Signature Witness Signature

_____

Date

Current Medications

Patient Name: Date:

Pharmacy:

Name	Strength	Dosage	Quantity	Duration