Last Name ________________________ **First Name** ________________________ **Middle Initial** ______
Date of Birth ____________________ **Sex:** ___ M ___F

Address: ____
City: _____________________ **State:** ____ **Zip:** _______________

Phone Number (__________) ____
Email Address ____
Occupation: ____

In case of an emergency, who should we notify? _______________________________
Phone (____________) ____________________

Shoe Size ________ **Shoe Width** _____ **Height** _________ **Weight** _________

What condition brought you into the office? _______________________________
How did you find out about us? ____

Primary Care Physician____

Pharmacy Name ___________________________ **Pharmacy Phone** ______________

Circle illnesses that you have had, then date Personal History:

Mumps	Pneumonia	Stomach/Ulcers
Chicken Pox	Tuberculosis	Intestinal Problems
Measles	Asthma	Hepatitis/Liver
Whooping	Bronchitis	Kidney Disease
Cough	Emphysema	Thyroid Disease
Scarlet	Pleurisy	Bladder/Cystitis
Fever	Stroke	Recent Infections
Smallpox/Polio	Gout	Blood Problems
Hypertension	Arthritis	Seizures
Diabetes	Cancer	Phlebitis/Blood Clot
(Hemaglobin A1c)	Heart Disease	Auto Immune
Rheumatic Fever	Venereal Disease	

Women - Are you pregnant? Yes ____ No _____

Please List All Medication that you are currently taking:

Name of Medication	Dosage and frequency	Used for

List All Surgical Operations, Hospitalizations or Injuries:

____
____
____

Allergies, Check the following: **I have no known allergies** ( )

Aspirin ( ) **Penicillin** ( ) **Iodine** ( ) **Codeine** ( ) **Sulfa Drugs** ( ) **Local Anesthetics** ( ) **Adhesive Tape** ( )
Other ____

Family History: Age, Health, Illnesses
Familial History of Foot Problems ________________
Familial History of Anesthetic Reactions
____
Parents ___________________________________

Social History:
Tobacco: Years __________ Packs/day __________
Alcohol ____________________
Recreational substance ________________________
Sibling(s) __________________________________

PRIVATE PAY ACKNOWLEDGEMENT

Thank you for choosing The Foot and Ankle Medical Group for your care. Please be aware that your office visit is considered a **private pay, out-of-pocket service for elective procedures and treatments**. This means that the fees for the consultation are due at the time of your appointment and are not covered by insurance.

Please note that the cost of the office visit does not include any additional diagnostic tests, treatments, or procedures. If these **elective services** are recommended during your visit, they will be charged separately **as out-of-pocket expenses**. You will be informed of any additional charges before services are rendered.

A holder of this medical debt contract is prohibited by Section 1785.27 of the Civil Code from furnishing any information related to this debt to a consumer credit reporting agency. In addition to any other penalties allowed by law, if a person knowingly violates that section by furnishing information regarding this debt to a consumer credit reporting agency, the debt shall be void and unenforceable.

Signature:____

I certify that I, and/or my dependent(s), have insurance coverage with (**Name of Insurance Company(ies))**
____and assign directly to **Dr.** ____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

____ ______________

Signature of Patient, Parent, Guardian or Personal Representative **Date**

____ __________________

Please print name of Patient, Parent, Guardian or Personal Representative **Relationship to Patient**

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF HIPAA PRIVACY PRACTICE GUIIDELINES

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office. You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement. By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations.

You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA). The patient understands that:

- Protected health information may be disclosed or used for treatment, Payment or health care operations
- The Practice has a Notice of Privacy Practices, and that the patient has the opportunity to review this Notice
- The Practice reserves the right to change the Notice of Privacy Policies
- The patient has the right to restrict the uses of their information, but the Practice does not have to agree to those restrictions
- The patient may revoke this Consent in writing at any time and all future disclosures wiD then cease
- The Practice may condition treatment upon the execution of this Consent

Patient's Name (print) ____

Signature ____ **Date** ________/_________/________

Relationship to Patient (if other than patient): ____