Southeast Podiatry
Excellence in Foot and Ankle Care

Patient Information

(Print legibly in Blue or Black Ink ONLY)

Last Name:	First Name:	M.I.
Address:	City:	State: Zip:
DOB: Sex: M/F	Shoe size: Height:	Weight:
Race: Home:	Work:	Cell:
Employer:		
Emergency Contact Name:	Emergency Contact Number:	
Primary Care Physician:	Primary Care Phone Number:	
Date of last visit with Primary Care Physician?		
Preferred Language:		

Medical Insurance/Policy Holder

Primary Insurance Company:		
Policy/ID Number:	Group Number:	
Policy Holder Last Name:	First Name:	SSN:
Relationship to Patient:	Policy Holder Date of Birth:	
Street Address:		
City:	State:	Zip:
Home:	Work:	Cell:
Secondary Insurance Company:		
Policy/ID Number:	Group Number:	
Policy Holder Last Name:	First Name:	SSN:
Relationship to Patient:	Policy Holder Date of Birth:	
Street Address:		
City:	State:	Zip:
Home:	Work:	Cell:

Responsible Party/Guarantor (__ check if same as patient)

Last Name:		First Name:
SSN:	DOB:	
Street Address:		
City:	State:	Zip:
Home:	Work:	Cell:

How did you hear about Southeast Podiatry?

o Primary Care Physician o Other Physician ___________________ o Internet

o Patient/Family/Friend o Newspaper o Other

Assignments of Medical Benefits/Authorization to Release Medical Information

I hereby authorize payments of medical benefits directly to physician for Medical Services provided. I authorize the Physician to release any information acquired in the course of any treatment necessary to process insurance claims to my insurance provider.

Initial ______

Privacy Practice agreement has been given to me to read. I fully understand all the information. If I have any questions I understand I can contact the Privacy officer at 770-675-7904. This notice discusses how my medical information may be used and disclosed as well as my rights as a patient. If any changes are made to this Privacy Practice agreement, I understand the information will be posted in the waiting area and copies will be available to me upon request.

Email Address: ______________________________________ ( ) check if okay to receive email reminder of appointments and email giving you access to Electronic Medical Records to view your medical records from Southeast Podiatry and any correspondence emails with the exception of lab results.

Pharmacy Name: ______________________________ Telephone Number: _________________________

Address:____

Patient Signature: _____________________________ ***Date:*** _________________

*Parent/Guardian Signature (if patient is a minor):*________________________________*Date:*_________

Name: ______________________________ ________**Height:** ___________ **Weight:** _______________**Shoe Size:**______

1. Brief description for the reason of your visit today? Please circle (Right or Left Foot) (Right or Left Toe 1, 2, 3, 4, 5)

____

2. Any Trauma (injury) that you are aware of that may have caused problem? _____________________

3. How long have you had this problem? ___________________________________

4. Please check all that applies regarding pain:

o Sharp o Aching o Radiating o Burning o Stabbing o Dull o Other_____________

5. Pain Level is: 0 1 2 3 4 5 6 7 8 9 10 (circle one)

6. Pain/Condition seems to get worse: (circle all that applies)

Walking Sitting Standing Lying down Elevating Other _____________

7. Pain/Condition seems to get better:

Walking Sitting Standing Lying down Elevating Other _____________

8. List any conservative treatments you have tried for your condition? (Ex. Soaking, Elevating, OTC med)
____

____

Diabetic Patients Only: Do you check your glucose? ______ How often? ______ Most Recent Reading______
Most Recent Hemoglobin A1C? ______________

Medical History

o Asthma	*o Anemia*	*o Arthritis*	*o COPD*
o Diabetes	*o High Blood Pressure*	*o High Cholesterol*	*o Stroke/TIA*
o Heart Rhythm Disorder	*o Heart Failure*	*o Heart Attack/Angina*	*o Blood clot in veins*
o Bronchitis	*o Reynaud's*	*o Gout*	*o Glaucoma/Eye Conditions*
o Cerebral Palsy	*o Multiple Sclerosis*	*o Parkinson's Disease*	*o Sarcoidosis*
o Blood Transfusion	*o Neuropathy*	*o Thyroid Disorder*	*o GERD/Reflux*
o Rheumatic Fever	*o Sickle Cell*	*o Colitis*	*o Crohn's Disease*
o Ulcerative Colitis	*o Lyme Disease*	*o HIV/Aids*	*o Sexual Transmitted Disease*
o Hepatitis B or C	*o Back/Neck Trouble*	*o Tuberculosis*	*o Lung Disease*
o Seizures/Epilepsy	*o Depression*	*o Rheumatoid*	*o Bi-Polar/Schizophrenic*
o Polio	*o Osteoarthritis*	*o Lupus*	*o Anxiety*
o Kidney Failure	*o Kidney Stones*	*o Kidney Dialysis*	*o Alzheimer's/Dementia*
o Cancer *Type:* *Chemotherapy: yes /no*	*o Other medical problems:* ______________________		

List any **Family History** checked as your medical history. (List relation and condition)

____

____

Surgical History

Please list any past surgeries:
____
____
____

Current Medications & Dosage

Patients 65 and over: Hospital Admission in last 6 months o Yes o No and/or Falls in last 6 months o Yes o No
Updated Vaccinations: Pneumonia o Yes o No, if yes when ______________________________

Allergies

o None o Codeine o Sulfa o Aspirin o Penicillin o Latex

o Adhesive Tape o Food Allergies o Other Allergies: ______________________

List Reaction to allergies checked: ____

Social History

o Single o Married o Divorced o Widowed o Significant Other/Partnered

Do you smoke? o Yes o No If yes, how many packs a day? _______ Have you ever smoked? ________
How long ago did you quit? ____

Do you drink alcohol? o Yes o No If yes, how often? ____________ How much? ______________

Have you ever used recreational drugs? o Yes o No

What is your current occupation? _____________________________ Disabled? o Yes o No

Women only: Hormones or Oral Contraceptive? ( )Yes ( ) No Breastfeeding? ( )Yes ( ) No Pregnant? ( ) Yes ( ) No

I believe I have answered all the questions on this form to be best of my knowledge. It is my responsibility to advise the physician and office staff of any changes in my medical history. I understand if I have answered any of the questions incorrectly it could affect my treatment by the physician. I hereby authorize the physician and his or her assistants of Southeast Podiatry to administer treatment as deemed necessary.

Patient's Signature ____ *Date:* ______________________

*Parent/Guardian Signature (if patient is a minor):*___________________________________ *Date:*______________

Financial Policy

1. If your plan requires a referral you must obtain this referral prior to being seen otherwise you will be responsible for all charges at time of visit. It is your responsibility to make sure that the physician is covered under your insurance network. You will not be seen require referral is not obtained and you refuse to pay for office visit.

2. All Deductibles, Co-pays, Co-Insurance and Out of pocket expense will be collected at the time of service.

3. We will file your claim for you if we are a participating provider in your plan. You will be responsible for any and all services in excess of your insurance limits as well as all non-covered services, durable medical equipment, and supplies.

4. We will mail you a statement for any outstanding balances not covered by your insurance for any reason.

5. Unpaid past due balances must be paid prior to seeing the physician for any appointments schedule unless a payment arrangement is in effect with the billing department.

6. In the event we have to send your account to debt collections, there will be a $50.00 processing fee added to the outstanding balance.

7. It is your responsibility to provide correct insurance information, present an insurance card, and state issued identification at the time of your appointment.

8. There is a $30.00 returned check fee charge.

9. To receive copies of your medical records a signed medical release form must be completed and records will be dispensed within 48-72 hours. There may be a charge for release of medical records. Fees will be due prior to receipt of these records.

10. There is a $15.00 charge for any disability forms, Family Medical Leave, and any other forms for administrative purposes. This fee is charged each time forms are to be completed.

11. Our office reserves the right to charge a $25.00 No Show/Cancellation Fee to any patient who fails to cancel their appointment without a 24 hour advanced notice. This fee will be billed directly to you and is nor reimbursable by insurance.

By signing below, you acknowledge that you understand and accept this financial policy.

____ ______________________________

Signature of Patient or Legal Guardian/Personal Representative *Relationship to Patient (If applicable)*

____ ________________________

Patients Name *Date*

For Office Use:

_____________________ __________________

Received by: Dispensed Date:

Authorization to Discuss Medical Information

I hereby authorize you to use or disclose the specific information described below only for the purposes described below.

Description of the specific information to be discussed:
___Appointment Date/Times
___Diagnosis
___Medications
___Lab Tests/Results
___Summary of Medical Records
___Care Plan
___Other (specify): ____

I authorize the release of information to the following:

Name: ____ Relationship:_____________________________

Name: ____ Relationship:_____________________________

Name: ____ Relationship:_____________________________

Name: ____ Relationship:_____________________________

This authorization shall remain in effect from the date signed below until (please check one):

- ☐ ____(specify expiration date or event)
- ☐ NO EXPIRATION DATE

I understand that:

- I may inspect or copy the protected health information to be used or disclosed.
- I may revoke this authorization in writing by contacting your office, attention Administrator.
- This authorization is giving Southeast Podiatry the right to discuss my medical information with the one or more people listed above.
- Information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient and will no longer be protected by HIPAA.
- The physician will forward record of my office visit and treatment plan to my Primary Care Physician unless otherwise stated.

☐ I do not consent to have my medical information or any other information pertaining to my care at Southeast Podiatry released.

____ ________________________________
Signature of Patient or Legal Guardian/Personal Representative *Relationship to Patient (If applicable)*

____ _________________________
Patients Name *Date*

AUTHORIZATION TO LEAVE MESSAGE

From time to time in caring for our patients, it may become necessary to contact you by telephone. Often our patients are not available when we call and we would like to be able to leave a detailed telephone message (i.e. lab results) when possible. In order to protect your privacy we need your written permission to leave detailed telephone messages on your answering machine, voice mail system or with a trusted family member. Please read the following choices and tell us whether or not we can leave voice mail regarding your medical information, such as lab and test results, and with whom we may leave it.

Please choose one of the following:

I, ______________________________, **DO/ DO NOT (circle one)** CONSENT for Southeast Podiatry staff, to leave detailed telephone messages regarding my medical care with the following options:

Home: ____

Cell: ____

Work/Other: ____

By signing below, I authorize Southeast Podiatry through its vendor, Practice Fusion to contact me via automated text and voice messages to remind me of my upcoming appointments.

I understand that message/data rates may apply.

I know that I am under no obligation to authorize Practice Fusion to send me appointment reminder text messages or telephone calls.

I may opt-out of receiving these communications from Practice Fusion at any time by calling Southeast Podiatry at 770-675-7904, or email appointments@southeastpod.com.

____ ______________________________
Signature of Patient or Legal Guardian/Personal Representative *Relationship to Patient (If applicable)*

____ ________________________
Patients Name *Date*

I **do not consent** to automated text messaging: