# New Patient Information

Patient Name:  Sex: M F D.O.B.:

What would you like to be called:  SS#:

Mailing Address:  City:

Zip:  Email:

Cell Phone:  Home:  Work:

Height:  Weight:  Shoe Size/Width:

Employer:  Occupation:

Emergency Contact:  Contact Phone:

Relationship to Patient:

Primary Care Physician:

Practice Name/Address:

Phone:  Fax:  Date of last visit:

Pharmacy Name:  Pharmacy phone number:

Pharmacy Address:

**PLEASE INCLUDE A COPY OF A PHOTO ID AND ALL INSURANCE CARDS**

Primary Insurance Name:

Policy/Contract #:  Group #:

Name of Policy Holder:  Policy Holder DOB:

Relationship to Patient:  Policy Holder SS#:

Secondary Insurance Name:

Policy/Contract #:  Group #:

Name of Policy Holder:  Policy Holder DOB:

Relationship to Patient:  Policy Holder SS#:

What is your chief complaint today?  Where?

When did this condition start?  years  month  days ago

What is the nature of your pain? Stabbing Radiating Sharp Dull Burning Aching

Itching Other:

Is your condition getting better or worse?

|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Rate your pain: | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | (severe) |
|  |  |  |  |  |  |  |  |  |  |

What seems to make your condition, pain worse?

What seems to make your condition, pain better?

Have you seen another physician for this problem? Yes No

If yes, doctor’s name:

Has this condition affected your ability to work, exercise or perform other daily activities? Yes No

If yes, how?

Is there history of injury? Yes No If yes, date of injury?

Is this work-related injury? Yes No

*Women: Breastfeeding? Yes No*

*Are you pregnant? Yes No If yes, how many weeks are you?*  *Due date:*

***Past Medical History (tick all that apply)*** *NONE*

**Cancer:** lung skin breast cervical prostate

**Neurological:** stroke neuropathy vertigo seizures migraines

**Skin:** eczema psoriasis ulcers vitiligo dermatitis hives

**Psychiatric:** bipolar depression anxiety claustrophobic dementia

**Respiratory:** emphysema asthma shortness of breath COPD

**Eyes/Ears/Nose/Mouth and Throat:** cataracts glaucoma hearing loss

**Genitourinary:** STD HIV UTI kidney stones kidney/bladder infections

**Hematologic/Immunologic:** dialysis anemia sickle cell bleeding disorder

**Gastrointestinal:** stomach ulcers hernia hepatitis reflux/GERD gallbladder disease

**Cardiovascular:** heart attack coronary disease high blood pressure irregular heart rhythm

**Musculoskeletal:** lupus osteoarthritis rheumatoid arthritis fibromyalgia gout back pain

**Metabolic:** hypoglycemia diabetes hypothyroidism hyperlipidemia osteoporosis

**Other:**

***Past Surgeries and Hospitalizations (tick all that apply)****NONE*

Tonsils/Adenoids Amputations Other Vascular Bypass Appendix

Gallbladder Hysterectomy Hernia Angioplasty

Coronary/Heart Bypass Other

***List or attach a complete list of all CURRENT MEDICATIONS, including vitamins/supplements:***

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  |  |  |  |  |
|  |  |  |  |  |

***Allergies:*** (tick) NONE Narcotics NSAIDS Penicillin Sulfa Aspirin Contrast Latex Iodine Shellfish Tape Gluten Intolerance Food Allergies Metal

Other:

How did you learn about ***Optimum Foot & Ankle Centers***?

I was referred by Dr.

A friend or another patient referred me

Insurance Website

Internet Search: Google Yahoo Bing Other:

Local Newspaper

I saw your practice sign/driving by

Other Source:

# Social History

Marital Status: Single Married Divorced Widowed Partnered

Have you ever used illicit drugs (pain pills, marijuana, cocaine, etc.)? Yes No

Do you have a history of alcohol or drug abuse including prescription medications? Yes No

Have you have ever used tobacco? Yes No If yes, amount per day

Age began:  Age quit:

Do you ever drink alcohol? Yes No If yes, How often:  How much:

# Family Medical History

Is there a family history of any specific medical conditions or diseases?

***Review of Symptoms: (tick any symptom that you have had in the last 6 months)*** *NONE*

**Neurological:** frequent headache limb weakness limb numbness dizziness tremors rigidity balance issues

**Skin:** rashes/hives skin discoloration lesions ulcers itching nail problems easy bruising unusual hair loss

**Respiratory:** persistent cough shortness of breath wheezing can’t breath lying flat  
coughing up blood

**Eyes/Ears/Nose/Mouth and Throat:** sore throat stiff neck nose bleeds hearing loss  
ringing in the ears

**Gastrointestinal:** nausea/vomiting difficulty swallowing abdominal pain  
heartburn/indigestion

**Cardiovascular:** palpitation irregular heartbeat exercise intolerance leg swelling  
leg pain when walking

**Musculoskeletal:** joint pain/stiffness joint swelling muscle weakness back pain  
muscle spasms falling

**Constitutional/Endocrine:** fever chills weakness/fatigue weight loss weight gain  
insomnia snoring excessive thirst excessive urination cold or heat intolerance

**Other:**

To the best of my knowledge, I have answered the questions on this form as accurately as possible. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor and staff of any changes in my medical status. I, the undersigned or as parent, legal guardian or power of attorney of the undersigned hereby authorize the physicians and their assistants of ***Optimum Foot & Ankle Centers*** to administer treatment as deemed necessary to myself or the patient below for whom I am responsible.

**Test Patient's Name for footer**

**Print Name of Patient Signature of Patient/Parent/Guardian/Power of Attorney Date**

Signature of Doctor Date

# Release of Medical Records/Information and HIPAA Compliance/Confidentiality

***Optimum Foot & Ankle Centers*** is HIPAA compliant. We make every effort to protect your privacy. We feel it is important you understand your patient rights to confidentiality. If you have any concerns, please see the manager. I understand ***Optimum Foot & Ankle Centers*** complies with HIPAA regulation. All medical records are confidential and cannot be disclosed without the written consent of the person to whom they pertain. I further understand that under Georgia law, I have the right to my medical records. I also understand that I may request my records be released to a physician and/or medical facility; however, this request must be made in writing. I understand that by law this office may only release medical records they generate as ***Optimum Foot & Ankle Centers***, they cannot release medical records from any other physician, hospital or facility. I agree to accept responsibility for any copying fees as provided by Georgia statues. I understand that employees have no responsibility or liability regarding this authorization. Furthermore, I have the right to complain to this practice or to secretary of HHS if I feel my privacy rights have been violated. It is the policy of this office that no retaliation of any type will be taken against a patient that files a complaint.

I **authorize** ***Optimum Foot & Ankle Centers*** to leave medical information on my answering machine and/or give my spouse my medical information. **Initials \_\_\_\_\_\_**

**OR**

If you **do not authorize** ***Optimum Foot & Ankle Centers*** to release any part of you medical records to anyone in your family or leave any medical information on your answering machine please let the receptionist know. **Initials \_\_\_\_\_\_**

By signing below you acknowledge that you have read, agree with and understand the above statements.

I understand that by signing this form, I am also authorizing that any holder of my medical information be able to release my medical information to the insurance carrier(s), the Social Security Administration, the health care financing administration, its intermediaries, carriers for this or any medical related claim. I, the undersigned, authorize the release of my medical records to other physicians, hospitals and/or healthcare facilities as needed to provide me with medical care. **Initials \_\_\_\_\_\_**

**Test Patient's Name for footer**

**Print Name of Patient Signature of Patient/Parent/Guardian/Power of Attorney Date**

I, the undersigned, understand that ***Optimum Foot & Ankle Centers*** has agreed to accept medical and/or health insurance for payment of my medical bills. Payment is required at the time that services are rendered. ***Optimum Foot & Ankle Centers*** is a participating provider of Medicare, and most PPO and HMO plans. Please check with the receptionist to see if we are participating with your insurance plan. Our office will file the insurance claims automatically. I understand that I am responsible for any co-pays, co-insurances or deductible amounts at the time of service. **Initials \_\_\_\_\_\_**

By my signature below, I acknowledge that I am fully responsible for any balances after Medicare and/or my health insurance has paid ***Optimum Foot & Ankle Centers***. This may be a result of my yearly deductible, co-insurance and/or co-payment, Durable Medical Equipment and any charges for services deemed to be non-covered, not pre-certified or not authorized by my insurance plan. **Initials \_\_\_\_\_\_**

I also understand that any benefits given to ***Optimum Foot & Ankle Centers*** by my insurance carrier is not a guarantee of my benefits as it may be subject to change. I also understand that it is my responsibility as the patient to get a referral if my policy requires a referral. I also understand that if I do not present a referral and it is necessary, my insurance company may deny the claim as a result of not having the referral. **Initials \_\_\_\_\_\_**

It is the policy of our office that all fees are due at the time of services are rendered whether by check, cash, or credit card unless prior arrangements have been made. We welcome frank discussion of services and fees at the time of treatment in order to avoid any misunderstandings. We are happy to file your insurance for you, however, regardless of insurance coverage; you are responsible for payment of your account abiding with the credit policy of this office. If fees are incurred in order to collect delinquent accounts, those fees will be the responsibility of the patient. We accept MasterCard, Visa, American Express, and Discover as well as cash or checks. Please note that if you write a check and it is returned, we will charge your account $25 for a non-sufficient fund fee. If your claim is not paid within 90 days, the claim will be transferred to patient responsibility and if timely payment is not received, the account may be referred to a collection agency or attorney. In the event that your account needs to be placed with an outside agency or attorney, you will be assessed an additional 30% of the balance to recover the collection charges. **Initials \_\_\_\_\_\_**

I authorize the release of any medical/surgical information necessary to process this claim and authorize payment of medical/surgical/medical equipment benefits to be made directly to ***Optimum Foot & Ankle Centers***. After all insurance payments have been paid; I fully understand that I am responsible for the remaining balance of my account. **Initials \_\_\_\_\_\_**

I give my consent for examination and treatment by ***Optimum Foot & Ankle Centers***. **Initials \_\_\_\_\_\_**

I acknowledge that I was provided a copy of Notice of Privacy Practices and that I have read and understood the Notice. **Initials \_\_\_\_\_\_**

I acknowledge that I have received and read the Financial Policy of ***Optimum Foot & Ankle Centers***. **Initials \_\_\_\_\_\_**

**Signature of Responsible Party Print Name Date**

**Responsible Party Mailing Address:** (if different from patient)

**Responsible Party Home Phone:**       **Cell:**