Patient Information

Name: _____ Male/Female _____

Address _____

City, State, Zip _____

Home Number _____ Cell _____

Email: _____

Pharmacy Name and Number _____

Date of Birth _____ Marital Status: M W D S

SSN _____ Race/ethnicity _____

Primary language spoken in home _____

Emergency Contact AND Phone Number _____

Employer/occupation/work # _____

Do you have a legal Power of Attorney? Yes No

If yes, NAME: _____ Relationship _____ PPH: _____

Who is your:

Primary Care Doctor _____ Last visit: _____

Cardiologist _____ Last visit: _____

Endocrinologist _____ Last Visit: _____

Pain Management _____ Last Visit: _____

Dermatology _____ Last Visit: _____

INSURANCE INFORMATION

Primary Insurance _____ 2nd Insurance _____

**If patient is a minor or insurance is NOT in your name, please list the Subscriber below

Name _____ DOB _____

Address _____

Mobile # _____ SSN _____

***IF YOU HAVE A COPY OF YOUR MEDICATIONS, YOU DON'T HAVE TO LIST. WE CAN MAKE A COPY

List all medications including ALL HERBAL SUPPLEMENTS that you are currently taking:

Include ALL BLOOD THINNERS (Aspirin, Plavix, Coumadin, Effient, Warfarin, etc...) Cinnamon and Fish Oil are BLOOD THINNERS. Also, list any diet medications (Adipex, Phentermine, etc)

_____

_____

_____

_____

Height _____ Weight _____

Do you have any medicine allergies?

Penicillin	Demerol	Sulfa
Codeine	Adhesive Tape	Local Anesthetic
Iodine Solution	Latex	Other:
I have no know medicine allergies		

Reason for visit today?_____ When did it start?_____

Previous treatments include (Circle all that apply)

Pain medication	Injection	Xrays
Physical Therapy	Antibiotics	Surgery
Bone Scan	Ice/Stretching	MRI
CT Scan	Hospitalization	Other

Circle your answers:

Did your pain/problem: Began suddenly Gradually develop over time

How would you describe the pain? No pain Sharp Dull Aching Burning
Radiating Itching Stabbing Other:_____

Since the pain began has it: Stayed the Same Become Worse Improved

What makes the problem or pain feel worse? Walking Standing Daily Activities Resting
Dress Shoes High Heels Flat Shoes Any Closed Toe Shoe Running

Does anything make it better?_____

IS THIS PROBLEM FROM AN INJURY?? _____

Patients Name: _____ **Date:** _____

Do you currently have trouble with any of the following on a regular basis?

Systemic: feeling poorly, fever. Chills, nausea, vomiting, unexplained weight change

Head/Eyes/Neck: blurred vision, double vision, headache, sore throat, persistent cough

Chest: palpitations, chest pain, difficulty breathing

Stomach: constipation, diarrhea, acid reflux

Neuro: dizziness, **NEW** numbness or burning in feet

Medical History: Circle all that apply

ADHD	**Diabetes: Insulin OR Non-Insulin**	**Heart Disease**
High Blood Pressure	**Diagnosed Poor Circulation**	**Arthritis**
Kidney Disease/Dialysis	**Asthma**	**Stroke**
Neuropathy	**Hepatitis**	**Liver Disease**
Sickle Cell Trait	**Sickle Cell Anemia**	**Blood Clots/DVT**
Stomach disorder	**Seizures or Epilepsy**	**Sleep Apnea Cpap**
Abnormal or Excessive Bleeding	**Difficulty Healing**	**Keloids or Thickened Scars**
Gout	**Low Back Pain**	**HIV Positive**
Lupus	**Rheumatoid Arthritis**	**High Cholesterol**
Cancer (past or present) What kind?	**Dementia/Alzheimer's Disease**	**Other:**

Prior Surgeries & What Year?

_____

_____

Social History:

Do you currently use tobacco? **Yes or No** How much/day? _____ How many years? _____

In the past, did you use tobacco? **YES or NO** Quit date? _____

Do you drink Alcohol? **YES or NO** How many drinks daily? _____

Do you use illegal drugs? **YES or NO** What kind? _____

Family History

Heart disease	**Stroke**
Cancer	**Diabetes**
Bleeding disorder	**Gout**
Lupus	**Rheumatoid Arthritis**

Acknowledgement of Notice of Privacy (HIPPA) and Consent to Use/Disclose Health Information

I acknowledge that I have had the opportunity to receive a copy of Appling Podiatry consent, demographic information, privacy practices (upon request). I understand that as part of my healthcare, this organization originates and maintains health records describing my health history, symptoms, examination, test results, diagnoses, treatment, and any plans for future care or treatment so that my provider can get paid, and for various uses related to my providers operations. I hereby consent to my provider using and disclosing my health information in connection with my treatment in order to get paid for services provided to me, and as necessary for the operations of the hospital. I acknowledge receipt of a copy of this facilities Notice of Privacy Practices (available upon request). I understand that this information serves as:

A basis for planning my care and treatment

A means of communication among the healthcare professionals who contribute to my care

A means by which insurance companies can certify that services billed were actually provided

A source of information for applying my diagnoses and surgical information to my bill

Appointment messages and medical messages may be communicated to me in the following ways:

Text message, email, or phone call to home/cell number (unless otherwise specified)

- By signing this form, I authorize the use and/or disclosure of my protected health information (PHI) as described on this form.
- I understand that if I authorize the release of my PHI to someone who is not required to comply with the federal privacy regulations, such information may be redisclosed and would no longer be protected.
- I understand that I may make changes regarding the disclosure of my PHI at any time and that I must notify the physician in writing of these changes. I am aware that my revocation is not effective to the extent that persons I have already authorized to use and/or disclose my PHI have acted in reliance upon this authorization.
- I understand that I have the right to inspect and copy my own PHI to be used or disclosed in accordance with the requirements of the federal privacy protection regulations found under 45 C.F.R. Section 164.521.

I authorize the release of my PHI to the following people:

_____ _____

_____ _____

Patient Signature: _____ Date _____

PATIENT FINANCIAL AGREEMENT

PLEASE READ THOROUGHLY AND SIGN BELOW

In consideration of the receiving services from Appling Podiatry

5779 Getwell Rd Bldg. A Suite 5Southaven, MS 38671 or any satellite office

1. All services are provided to you with the understanding that you are responsible for the cost regardless of your insurance coverage. Please be aware that not all services are a covered benefit with different insurance companies. We bill your insurance company as a courtesy, but you are still ultimately responsible for payment of all services you receive. All health plans are not the same and do not cover the same services. We will attempt to verify benefits for certain specialized services; however, you remain responsible for charges to any service rendered.
2. **Deductible/co-insurance and/or copay will be due at the time of service.** We accept cash, check, and credit card. Any past due balance on account will be due or payment arrangements made prior to your next appt.
3. You are responsible for knowing if a referral authorization is required by your insurance company. Make sure you know what physicians are in your plan, what facilities are covered, and what ancillary services you must use. If we can be of assistance, please let us know. KNOW YOUR BENEFITS. **It is your responsibility to notify this office of any insurance coverage changes in addition to address or phone number changes.** In the event that you do not, you will be responsible for any charged denied.
4. Any unpaid charges over **90 days old** (without a prior payment arrangement) will be turned over to our outside collection agency with additional collection fees (up to 50%). You are responsible for any collection fees, legal fees, or court costs incurred in the collection process.
5. Returned checks are subject to a $40 return check fee.
6. Cancelled without 48-hour notice or no- show surgeries will result in a $250 cancellation fee.

We do understand that temporary financial problems may affect timely payment. We encourage you to communicate any such problems so that we can assist you in the management of your account.

DISCLOSURE OF MEDICAL INFORMATION AND ASSIGNMENT OF BENEFITS: I authorize Appling Podiatry to share my medical information and medical records to my insurance company and third-party payers. I assign any benefits I may have for reimbursement of my medical treatment received by compensation benefits, or any other payer with whom services are filed.

_____ _____

Patient/Guardian Signature Date