Arlington Podiatry Center

(PRINT LEGIBLY)

Date: _____ Name _____ Age: _____
(LAST) (FIRST) (M.I.)

DOB: ____/____/_____ Social Security #: _____-_____-_____ Sex: M____ F____

Home Phone: ( ) _____-_____ Work: ( ) _____-_____ Mobile: ( ) _____-_____

Address: _____City: _____ State: _____ Zip: _____

Marital Status: Minor ____ Single ____ Married ____ Widowed ____

EMAIL ADDRESS: _____

Emergency Contact Person: _____ Phone: ( ) _____-_____

Relationship to Patient: _____

How did you hear about our Practice? (Circle one) Yellow pages Other Patient Dr's Referral

Insurance Co. Church Bulletin Health Magazine Internet
Friend: _____

Race_____ Ethnicity_____ Primary Language_____

Referring Physician: _____ Phone number: ( ) -

Primary Care Physician: _____ Phone number: ( ) -

***Primary Insurance Co._____ Name of Policy Holder:_____**

Relationship: _____ Policy Holder DOB: _____

Policy ID#: _____ Group #: _____

***Secondary Insurance Co._____ Name of Policy Holder:_____**

Relationship: _____ Policy Holder DOB: _____

Policy ID#: _____ Group #: _____

Policy Holder's Employer_____ Phone #:_____

I understand that I am liable for any charges incurred at the Arlington Podiatry Center. I will make prompt payment to the Arlington Podiatry Center for any visit not covered by my insurance company. I understand that if my insurance dictates, I must choose the Arlington Podiatry Center and/or one of the doctors within as my primary care physician and that if I do not I will be liable for the charges incurred. I authorize payment of benefits to Arlington Podiatry Center for services rendered and the release of medical information necessary to determine these benefits payable for related services. **Patients who do not cancel appointments 24 hours in advance will be charged $35.**

If you do not have insurance, payment in full is required when services are rendered.

Date _____ Signature _____

MEDICAL HISTORY

Reason for your visit: Date when symptoms began and a description of the symptoms

_____

_____

_____

If problem is accident related, indicate date accident occurred and place of injury

_____

_____

Have you been treated by another physician for this problem? If Yes, list physician's name and treatment

_____

_____

Medical history (check all that apply)

AIDS/ HIV	□ Yes	□ No	Heart Disease	□ Yes	□ No
Anemia	□ Yes	□ No	High Blood Pressure	□ Yes	□ No
Arthritis	□ Yes	□ No	Kidney Problems	□ Yes	□ No
Artificial Heart Valve or Joints	□ Yes	□ No	Liver Disease	□ Yes	□ No
Asthma	□ Yes	□ No	Low Blood Pressure	□ Yes	□ No
Back Problems	□ Yes	□ No	Anxiety Problems	□ Yes	□ No
Bleeding Disorder	□ Yes	□ No	Psychiatric Care	□ Yes	□ No
Cancer	□ Yes	□ No	Respiratory Disease	□ Yes	□ No
Chemical Dependency	□ Yes	□ No	Rheumatic Fever	□ Yes	□ No
Chest Pain	□ Yes	□ No	Shortness of Breath	□ Yes	□ No
Circulatory Problems	□ Yes	□ No	Sinus Problems	□ Yes	□ No
Diabetes	□ Yes	□ No	Stroke	□ Yes	□ No
Epilepsy	□ Yes	□ No	Tuberculosis	□ Yes	□ No
Eye Problems	□ Yes	□ No	Ulcers	□ Yes	□ No
Gout	□ Yes	□ No	Varicose Veins	□ Yes	□ No
Headaches	□ Yes	□ No	Weigh Loss, unexplained	□ Yes	□ No
Neuropathy	□ Yes	□ No			

Other past medical History _____

Do you have history of diabetes in your family? □ Yes □ No If yes, your relationship:_____

Have you ever had Surgery? If yes, please list name:

1._____ 2._____ 3_____

4._____ 5._____ 6._____

Are you allergic to any medications? YES___ NO___

Penicillin ___ Aspirin ___ Novocain ___ Other _____

List current medication(s): _____

**Your Pharmacy's name and phone #: _____

Do you (circle): Drink alcohol? Smoke tobacco? If yes, how much? _____

Do you experience abnormal bleeding with surgery, cuts, extractions, or trauma? ☐ Yes ☐ No

Shoe Size: _____ Height: _____ Weight: _____

Patient Consent

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 sections 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 of health care operations.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health 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**).

- Protected health information may be disclosed or used to 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 and receive a copy if request by the patient or their representative.
- The Practice reserves the right to change the Notice of Privacy Polices.
- 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 will then cease.
- The Practice may condition treatment upon the execution of this Consent.
- This office may leave a voice message regarding schedule appointments on answering systems.
- I have seen this Office's Notice of Privacy Practices and consent to it polices.

This consent was signed by: _____ Date: _____
(Print Name of Patient or Representative)

Signature: _____

_____
Relationship to Patient (if other than patient)