

PATIENT INFORMATION

Age _____ DOB _____ / _____ / _____ (____) Male (____) Female

Full Name _____

Address _____

City/State/Zip _____

Cell Phone _____ Home Phone _____

Which you prefer to be called on first: () Cell () Home

Email _____

Whom may we release medical information to: _____

Employer _____ Occupation _____

Emergency Contact _____ Phone (____) _____ Relationship: _____

Pharmacy _____ Address _____ City _____

Family physician: _____ Phone# _____ Last seen: _____

DIABETIC PATIENTS: Doctor who treats your Diabetes: _____ Last seen: _____

| | | | |
|-----------------------------------|--------------------------------------|---|--|
| MARTIAL STATUS: | PRIMARY LANGUAGE: | ETHNICITY: | RACE: |
| <input type="checkbox"/> Married | <input type="checkbox"/> English | <input type="checkbox"/> NOT Hispanic or Latino | <input type="checkbox"/> White |
| <input type="checkbox"/> Single | <input type="checkbox"/> Spanish | <input type="checkbox"/> Hispanic or Latino | <input type="checkbox"/> Native Hawaiian or Pacific Islander |
| <input type="checkbox"/> Widowed | <input type="checkbox"/> Other _____ | <input type="checkbox"/> Decline | <input type="checkbox"/> Asian |
| <input type="checkbox"/> Divorced | | | <input type="checkbox"/> Black or African American |
| | | | <input type="checkbox"/> American Indian or Alaskan Native |
| | | | <input type="checkbox"/> Decline |

HOW CAN WE CONTACT YOU? (check ALL that apply)

| | | | |
|--------------------------------|-------------------------------|--------------------------------|---------------------------------------|
| <input type="checkbox"/> Phone | <input type="checkbox"/> Mail | <input type="checkbox"/> Email | <input type="checkbox"/> Text Message |
|--------------------------------|-------------------------------|--------------------------------|---------------------------------------|

OKAY TO LEAVE MESSAGE WITH:

| | | |
|------------------------------------|--|---|
| <input type="checkbox"/> Self Only | <input type="checkbox"/> Patient and/or spouse | <input type="checkbox"/> Anyone answering phone |
|------------------------------------|--|---|

HOW DID YOU HEAR ABOUT US?

| | | | | | | |
|---------------------------------|---------------------------------|--|-------------------------------|------------------------------------|-----------------------------------|--------------------------------------|
| <input type="checkbox"/> Friend | <input type="checkbox"/> Google | <input type="checkbox"/> Doctor Referral | <input type="checkbox"/> Yelp | <input type="checkbox"/> Insurance | <input type="checkbox"/> Internet | <input type="checkbox"/> Other _____ |
|---------------------------------|---------------------------------|--|-------------------------------|------------------------------------|-----------------------------------|--------------------------------------|

INSURANCE INFORMATION:

| | |
|-------------------------------|---------------------|
| PRIMARY Insurance Name | Member ID #: |
| Policy Holder Name & Birthday | DOB: / / |
| Policy Holder Employer | |

| | |
|-------------------------------|---------------------|
| SECONDARY Ins. Name | Member ID #: |
| Policy Holder Name & Birthday | DOB: / / |

Notification of Changes

If/when any of the above information, (i.e. name, phone number, insurance,) changes, I will provide the updated information promptly.

X _____ DATE _____
Patient's Signature or Parent/ Legal Guardian

MEDICAL HISTORY

PATIENT NAME: _____

State in your own words your medical reason(s) for coming into our office:

| | |
|-------------------------|---|
| Shoe Size: _____ | Are you a current smoker? Yes No |
|-------------------------|---|

MEDICATIONS- Please list all medications that you currently use:

ALLERGIES- Are you allergic to or have you ever reacted to any of the following?

| | | | | | |
|-----|----|-----------------|---------------------|----|------------------------------|
| YES | NO | ASPRIN | YES | NO | LIDOCAINE (LOCAL ANESTHESIA) |
| YES | NO | BAND-AIDS/ TAPE | YES | NO | SULFA DRUGS |
| YES | NO | LATEX | YES | NO | PENICILLIN |
| YES | NO | STEROIDS | OTHER: _____ | | |

YOUR Past Medical History: Have YOU ever HAD or HAVE any of the following?

CIRCLE ALL THAT APPLY

| | |
|--|---|
| <p>Eyes : Cataract Glaucoma</p> <p>ENTM : Trouble Hearing</p> <p>Integumentary: Eczema Odor Sweaty feet</p> <p>Allergies: Seasonal Allergies</p> <p>Musculoskeletal : Gout Arthritis</p> <p>Neurological: Cramping (legs or feet) Numbness (legs or feet) Tingling (legs or feet) Burning (legs or feet) Seizure</p> <p>Social: Alcoholism Drug Abuse</p> | <p>Respiratory: Asthma COPD</p> <p>GI: GERD Stomach ulcers</p> <p>CVS: Stroke Kidney disease Heart Disease High Blood Pressure</p> <p>Endocrine: Diabetes Thyroid disorder Anemia</p> <p>Psychiatry: Depressed Anxiety</p> <p>Immunology: Cancer HIV/AIDS</p> <p>() NONE OF THE ABOVE</p> |
|--|---|

FAMILY Past Medical History: Circle ALL that apply

| | | | | | | |
|----------------|----------|----------------|--------------|--------|------|---------|
| Father: | Diabetes | Kidney Disease | Hypertension | Cancer | None | Unknown |
| Mother: | Diabetes | Kidney Disease | Hypertension | Cancer | None | Unknown |

FOR WOMEN ONLY: ARE YOU PREGNANT? _____ IF SO HOW MANY MONTHS? _____

X _____
Patient's Signature or Parent/ Legal Guardian

Date

PATIENT NAME: _____

Authorization for Insurance to Pay

I hereby authorize payment of medical benefits billed to my insurance company to be paid directly to Trinity Foot Center, PC, the office of Lisa J. Brandy, DPM. I hereby agree to promptly pay for any service(s) provided to me not covered by my insurance policy. I agree to pay all co-payments, deductibles, coinsurance, and products sold through Trinity Foot Center, PC.

I authorize the above named provider to release to the Social Security Administration or its intermediaries any information needed for the claim or related medical claim. I further permit a copy of this authorization to be used in place of the original. I understand that I am financially responsible for the charges not covered by my insurance program.

Non-Covered Services

It is important to understand that some of the services provided to you may not be covered under your current insurance plan. Therefore, it is important that you check with your insurance company to verify your benefits. You will be responsible for full payment of any services not covered by your insurance at the time of your visit.

Surgery

Some minor surgical procedures are performed in our office. Most insurance carriers put these in the category of "surgery", meaning that the procedure may be applied to a surgical deductible or coinsurance. Therefore, you may be billed for an amount over and above the usual visit co-payment at your visit. If the procedure is not covered by your insurance, we will require 100% payment at the time of the surgery.

Appointments

It is our goal to provide services to you in the most comfortable and timely manner possible. In order to achieve this, we ask that you be on time for your appointments. We realize your time is valuable and we endeavor to keep on schedule, while providing each patient with personalized care. However, emergencies do occur, and may cause delays in our schedule. We will try to keep you informed of these delays should they arise. **If you must cancel an appointment, we ask that you kindly notify us at least 24 hours in advance. There is a \$25 fee for each no show occurrence.**

Prescription Refills

Prescription refills or change requests will be handled within 24 hours of the receipt of the request during regular office hours. Please contact your pharmacy so that a written request can be faxed to our office. No prescription refill or change requests will be handled after regular office hours or on the weekend.

Acknowledgment of Receipt of Notice of Privacy Practices

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read, if I so chose) and understood the notice.

Thank you for choosing us for your foot care needs. If you have any questions regarding these policies, please notify a member of our business office during regular hours. We will do our best to ensure your understanding of our policies so that we may concentrate on you and your care. I acknowledge that I have read and understand the contents of the financial and office policies for Trinity Foot Center, PC.

X _____ Date _____
Patient's Signature or Parent/ Legal Guardian