Welcome to our Practice

PATIENT INFORMATION

Date _____ Occupation _____

Last name _____ Employer/School _____

First name _____ Phone # Home _____

Address _____ Mobile _____

City _____ Work _____

State _____ Zip _____ Email _____

Date of birth _____ Age _____

SS#/HIC Patient ID # _____

In case of an emergency contact:

Name: _____

Number: _____

INSURANCE ASSIGNMENT AND RELEASE

I certified that I have insurance coverage with

_____

and assigned directly to Gainesville Podiatry Associates / Dr. Berens or Dr. Heiser all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by my insurance. I authorized the use of my signature on all insurance submissions.

The above named doctor may use my healthcare information and may disclose my information to the above named insurance company and their agents for the purpose of obtaining payment and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed for one year from the date signed below.

MEDICARE AUTHORIZATION

I request that payment for authorized Medicare benefits and if applicable Medigap benefits be made either to me or on my behalf to Gainesville Podiatry Associates / Dr. Berens or Dr. Heiser for any services furnished to me by that provider.

To the extent permitted by law and authorized any folder of medical or other information about me to release to the centers for Medicare and Medicaid services, might Medigap insurer, and their agents any information needed to determine these benefits or benefits or related services.

_____ _____

Signature of Beneficiary, Guardian or Personal Representative Date

What is your present foot or ankle difficulty? Right Left Both

_____

_____

_____

How long has it been a problem? _____

What have you done to treat this on your own? _____

_____

_____

_____

Preferred Pharmacy: _____

MEDICAL HISTORY

All information is strictly confidential

Cardiovascular

___ Chest Pain
___ Heart Disease
___ High Blood Pressure
___ Irregular Heartbeat
___ Stroke / TIA
___ High Cholesterol
___ Poor Circulation
___ Phlebitis / Blood Clots
___ Leg Cramps
___ Sickle Cell Disease
___ Anemia

Endocrine System

___ Diabetes
Last HgbA1c _____
___ Gout
___ Hepatitis
___ HIV / AIDS
___ Thyroid Disease
___ Rheumatoid Arthritis
___ General Arthritis

Respiratory

___ Asthma
___ COPD

Gastrointestinal

___ Kidney Failure / Dialysis
___ Gastric Reflux
___ Stomach Ulcers
___ Irritable Bowel Syndrome - IBS

Skin

___ Psoriasis
___ Ulcers / sores
___ Excessive Scarring
___ Skin Cancer

Height:_____ Weight:_____

Other: _____

Primary Physician: _____ **Last Visit:** _____

Family History: Does / did your mother or father have any of the medical conditions above?

Mother _____ Father _____

Vaccinations: **Pneumonia:** Prevnar 13 (PCV13) ____ Pneumovax (PPSV23) ____ Date _____

Flu Shot: Date _____ **Decline** due to allergy/sensitivity _____ **Decline** _____

Surgical History

___ Appendectomy
___ Cholecystectomy
___ Heart Bypass
___ Stent heart / extremity
___ Hysterectomy
___ Hip Replacement
___ Knee Replacement
___ Knee Surgery/Arthroscopy
___ Hand Surgery
___ Shoulder Surgery

Foot Surgery Right / Left Both
___ Bunion Surgery
___ Hammertoe Surgery
___ Neuroma Surgery
___ Heel Surgery
___ Other: _____

Other surgeries: _____

_____

List medications you are currently taking: _____

_____

_____

Medication Allergies: _____

Environmental Allergies: _____

Food Allergies: _____

Social Habits:

Do you drink alcohol? No Yes Social / Daily Quantity _____

Do you use tobacco? No Yes _____ Pks / _____ Day _____ Years

Signatures

To the best of my knowledge, the information provided is complete and correct. I understand that it is my responsibility to inform my doctor if I or my minor child, have any changes in our health status, or if there are any changes with regard to our health insurance. I understand I may be responsible for services provided if I have not provided accurate information regarding health care coverage as well as being responsible for any co-pays, coinsurance or deductibles as determined by my healthcare plan.

_____ _____

Signature of the Patient, Parent, Guardian or personal representative. Date

Patient HIPAA Authorization Form

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient's Rights section describing your rights under the law. You have the right to review your Notice before signing this form. 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 or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you acknowledge our use and disclosure of protected health information about your treatment, payment, and health care operations. You have the right to revoke this disclosure in writing, signed by you.

However, such a revocation shall not affect any disclosure we have already made in reliance on your prior Acknowledgment. The Practice provides this form in order to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:

- Protected health information may be disclosed or used for treatment, payment or health care operations
- The Practice has a Notice of Privacy Practices and that the patient has an opportunity to review this Notice
- The Practice reserves the right to change the Notice of Privacy Practices
- The patient has the right to restrict the use of their information, but the Practice does not have to agree with those restrictions
- The patient may revoke this Authorization, in writing, at any time and all future disclosures will then cease

The Practice may condition receipt of treatment upon the execution of this Authorization

I, _____date_____do hereby consent and acknowledge my agreement to the terms set forth in the HIPAA INFORMATION FORM and any subsequent changes in the office policy. I understand that this consent shall remain in force from this time forward.

Release of Information Authorization

Please allow those listed below to access my health, insurance and financial information:

NAME	**Relationship**
_____	_____
_____	_____
_____	_____