Bellevue Podiatry

PATIENT HEALTH HISTORY

(Please print)

Patient Name: _____ Date of Birth: _____ Age: _____

How would you like to be addressed? _____ Sex: □ Male □ Female

□ Minor □ Single □ Married □ Widowed □ Divorced □ Partnered for ___ years

Address: _____ Apt #: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Other Phone: _____

Email Address: _____

Employer: _____ How long? _____

Occupation: _____ Student: □ Full time □ Part-time

Person Responsible for Account *(If different from above)*

Name: _____ DOB: _____ Relationship: _____

Address: _____ City: _____ State: _____ Zip: _____

INSURANCE INFORMATION

(Skip over if you handed Office Manager your card)

Primary Insurance Company: _____ Subscriber I.D. #: _____

Secondary Insurance Company: _____ Subscriber I.D. #: _____

Primary Carder Holder: □ Self □ other; relationship: _____

Primary Card Holder's Name: _____ **Their Date of Birth:** _____

MEDICAL INFORMATION

Primary Care Physician: _____ Last Visit: _____

Former Podiatrist: _____ Last Visit: _____

Height: _____ Weight: _____ Shoe Size: _____ Did you receive flu shot this season? □ Yes □ No

Do you Smoke? □ Yes □ No Amount per day: _____ How long? _____

Do you drink Alcohol? □ Yes □ No Amount per day: _____ □ Beer □ Wine □ Liquor

Allergies to Medications: □ Adhesive/Tape □ Aspirin □ Codeine □ Demerol □ Iodine □ Local Anesthetics
□ Anticoagulant Therapy □ Novocain □ Penicillin □ Sea foods □ Sulfa □ Seasonal □ Food □ Latex
□ No known drug allergies Other _____

List of current Medications you are taking:

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

□ I am not taking any medicines

Emergency Contact: _____ ***Phone:*** _____

Flip Over, Back page

Pharmacy used: _____ Location/Phone: _____

FOOT AND ANKLE

What problem brings you to the Doctor today? _____
How long have you had these problems? _____
Have you ever broken a bone in your foot or ankle? □ No □ Yes Where? _____ When? _____

Please indicate which foot problems you now have or have had in the past:
□ Ankle Pain □ Athlete's Foot □ Corns & Calluses □ Cramps or numbness □ Flat feet □ Foot or leg cramps
□ Heel Pain □ Ingrown toenails □ Plantar warts □ Swelling in ankles or feet □ Tired feet □ Fungus

Do you have/or have ever had any of the following? Please check yes or no.

	(Patient)				*(Patient)*		
Diabetes – Type _____	□ Yes	□ No	□Family	Blood disease	□ Yes	□ No	□Family
Neuropathy	□ Yes	□ No	□Family	Gout	□ Yes	□ No	□Family
Rash	□ Yes	□ No	□Family	MRSA Infections	□ Yes	□ No	□Family
Back Problems	□ Yes	□ No	□Family	Headaches	□ Yes	□ No	□Family
Low blood pressure	□ Yes	□ No	□Family	Bleed easily/profusely	□ Yes	□ No	□Family
Anemia (low blood count)	□ Yes	□ No	□Family	Hepatitis- Type ___	□ Yes	□ No	□Family
Arthritis	□ Yes	□ No	□Family	HIV/AIDS	□ Yes	□ No	□Family
High blood pressure	□ Yes	□ No	□Family	Shortness of Breath	□ Yes	□ No	□Family
Liver trouble	□ Yes	□ No	□Family	Stroke	□ Yes	□ No	□Family
Kidney trouble	□ Yes	□ No	□Family	Thyroid Problems	□ Yes	□ No	□Family
Tuberculosis	□ Yes	□ No	□Family	Heart trouble	□ Yes	□ No	□Family
Varicose veins	□ Yes	□ No	□Family	Visual problems	□ Yes	□ No	□Family
Cancer - Type _____	□ Yes	□ No	□Family				

Are there any other medical conditions the doctor should be aware of? Please mention here: _____
_____

Surgeries – Indicate what type/year

_____
_____
_____

Hospitalized (not surgeries) Indicate why/year

_____
_____
_____

I hereby authorize the doctor and/or her assistant to initiate the diagnosis and treatment of my condition with x-rays, examination, photographs and/or injections, as necessary. I hereby authorize my insurance benefits to be paid directly to the physician. I understand I am financially responsible for any balance due. I understand it is my responsibility to obtain any pre-authorization and/or referrals needed for my care by a specialist. I authorize the doctor or insurance company to release my information required for my claims. I authorize the doctor to release specific information concerning my illness and/or treatment to any healthcare provider involved with my treatment and care.

Patient Signature: _____ Date: _____

NOTICE OF PRIVACY PRACTICES

ACKNOWLEDGMENT OF RECEIPT

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

*** Please make a selection from the following List:***

☐ I authorize Bellevue Podiatry to leave detailed voicemail messages regarding appointments only.

☐ I authorize Bellevue Podiatry to leave detailed voicemail messages regarding my appointments AND my care, and/or my treatment information at the phone number I have provided.

☐ I **DO NOT** authorize Bellevue Podiatry to leave detailed voicemail messages regarding appointments, my care, and/or treatment information at the phone number I have provided.

_____

Patient Name (Please Print)

_____ _____

Signature Date

_____ _____

Parent or Authorized Representative (if applicable) Relationship

The following is the privacy policy of Bellevue Podiatry, as described in the Health Insurance Portability and Accountability Act of 1996 and regulations promulgated there under, commonly known as HIPAA. Under HIPAA, you have certain rights with respect to your personal health information. The following is a brief overview of your rights and our duties with respect to enforcing those rights. HIPAA requires Covered Entity by law to maintain the privacy of your personal health information and to provide you with notice of Covered Entity's legal duties and privacy policies with respect to your personal health information. We are required by law to abide by the terms of this Privacy Notice.

Your Personal Health Information

We collect personal health information from you through treatment, payment and related healthcare operations, the application and enrollment process, and/or healthcare providers or health plans, or through other means, as applicable. Your personal health information that is protected by law broadly includes any information, oral, written or recorded, that is created or received by certain health care entities, including health care providers, such as physicians and hospitals, as well as, health insurance companies or plans. The law specifically protects health information that contains data, such as your name, address, social security number, and others, that could be used to identify you as the individual patient who is associated with that health information.

Uses or Disclosures of Your Personal Health Information

We will use and disclose your health information in order to treat you or assist other healthcare providers in treating you. We may also disclose your health information in order to obtain payment for services rendered to you by us or health care providers may not use or disclose your personal health information without your permission. Further, once your permission has been obtained, we must use or disclose your personal health information in accordance with the specific terms that permission. We may not disclose patient health information via email, as a secured network is not guaranteed. In the following circumstances, we ay disclose your health information without your written authorization: With the exceptions stated below in more detail in the Notice of Privacy Practices, we will not use or disclose your health information without your written authorization.

- To family members or close friends who are involved in your health care
- For purposes of public health safety
- To government agencies for purposes of their audits, investigation and other oversight activities
- To government authorities to protect public safety or to assist in apprehending criminal offenders
- When required by court orders, search warrants, subpoenas and as otherwise required by the law

Patient Rights

As our patient you have the following rights:

- To have access to and may copy your health information
- To receive an accounting of certain disclosures we have made of your health information
- To request restriction as to how your health information in used or disclosed
- To request that we communicate with you in confidence
- To request that we amend your health information
- To receive notice of our privacy practices