

WELCOME TO SHORE FOOT & ANKLE

Patient Information Sheet

All of your personal and medical information will remain confidential as required by HIPPA privacy regulations.

Last Name: _____ First Name: _____ Middle: _____

Home Address: _____

City/State/Zip: _____

Home Phone: _____ Work: _____ Cell: _____

E-Mail: _____

Social Security Number: _____ Sex (M/F): _____ Date of Birth: _____

Marital Status: Single / Married Employer: _____

Spouse's Name: _____ Spouse's Date of Birth: _____

Spouse's Employer: _____ Spouse's Work Phone: _____

Nearest Friend or Relative to Notify in an Emergency - other than spouse:

Phone Number: _____

Primary Care Physician: _____

Phone: _____ Fax: _____

Address: _____ Date of Last Exam: _____

Referred by: _____ How did you hear about us?: _____

Name of Pharmacy: _____ Phone: _____

INSURANCE INFORMATION

(Please present valid insurance cards and picture ID)

Insurance Company Name:

Policy Holder

Policy Number

1. _____

2. _____

If a dependent: Responsible Party/Health Insurance Holder's Name:

Policy Holder's Date of Birth: _____ Social Security Number: _____

Address: _____ Phone: _____

Employer: _____ Work Phone: _____

(Please complete other side of page)

PATIENT INFORMATION QUESTIONNAIRE

All of your personal and medical information will remain confidential as required by
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DATE: _____ NAME: _____

Welcome to Shore Foot & Ankle. In order to treat you best, please answer the following questions in order to get a detailed medical history and description of your problem.

What problems are you currently having? _____

When did the problem begin? What was the date of the injury? _____

Describe the pain or problem. _____

When does it occur? What makes it better/worse? _____

What treatments have you had for your problem? _____

Past Medical History (please check all that apply):

- | | | | |
|---|--|--|---------------------------------------|
| <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Seizures | <input type="checkbox"/> Liver Disease | Sexually Transmitted Diseases: |
| <input type="checkbox"/> Cataracts | <input type="checkbox"/> Gout | <input type="checkbox"/> Hepatitis (Type): _____ | <input type="checkbox"/> HIV |
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Kidney Disease/Stones | <input type="checkbox"/> Alcohol/Substance Abuse | <input type="checkbox"/> Syphilis |
| <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Bleeding Disorders | <input type="checkbox"/> Back Problems | <input type="checkbox"/> Herpes |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Anemia | <input type="checkbox"/> Pinched Nerves | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> COPD | <input type="checkbox"/> Blood Clots | <input type="checkbox"/> Neurological Disorders | Psychological Disorders: |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Sickle Cell | <input type="checkbox"/> Stroke | <input type="checkbox"/> Anxiety |
| <input type="checkbox"/> Congestive Heart | <input type="checkbox"/> Poor Circulation | Muscle Weakness: | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Leg Swelling | <input type="checkbox"/> Left | <input type="checkbox"/> Bipolar |
| <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Raynaud's Disease | <input type="checkbox"/> Right | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Heart Valve Implants | <input type="checkbox"/> Acid Reflux | <input type="checkbox"/> Arthritis (Location): _____ | Skin Problems: |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> GI Bleeding | <input type="checkbox"/> Cancer (Location): _____ | <input type="checkbox"/> Eczema |
| <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Artificial Joints: _____ | <input type="checkbox"/> Psoriasis |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Thyroid Disease | | <input type="checkbox"/> Other: |

Other Health Ailments: _____

Current Medications (Include all non-prescription, OTC, vitamins and supplements):

PATIENT INFORMATION QUESTIONNAIRE

Allergies (Check all that apply and describe the reaction you had):

- | | | |
|--|--|---|
| <input type="checkbox"/> Latex | <input type="checkbox"/> Sulfa | <input type="checkbox"/> Food: _____ |
| <input type="checkbox"/> Ciprofloxacin | <input type="checkbox"/> Penicillin | |
| <input type="checkbox"/> IVP Dye | <input type="checkbox"/> Adhesive Tape | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Aspirin | <input type="checkbox"/> Seafood | |
| <input type="checkbox"/> Novocaine | <input type="checkbox"/> No Known Allergies | <input type="checkbox"/> Environmental: _____ |
| <input type="checkbox"/> Iodine/Betadine | | |
| <input type="checkbox"/> Codeine | | |
- Reaction: _____
-

Past Surgical History (Describe any and all surgical procedures on your body):

Have you ever had a bad reaction or allergic reaction to anesthesia? Yes / No (Describe):

Have you or a family member been diagnosed with malignant hyperthermia? Yes / No

Social History

Education Level: _____

Current Job Description: _____

Do you smoke tobacco Products? Yes No Occasionally Quit ____ years ago

Do you drink alcohol? Yes No Occasionally Daily Quit ____ years ago

Do you use recreational drugs? No Yes, Type _____ Daily Occasionally
Quit ____ years ago

Shoe Size: _____ Height: _____ Weight: _____

Family History

Mother - Alive Deceased Age _____ Medical Problems: _____

Father - Alive Deceased Age _____ Medical Problems: _____

Brothers/Sisters Medical Problems: _____

(Please complete other side of page)

REVIEW OF SYSTEMS

Please indicate if you are currently suffering from any of these problems on today's visit. (Check all that apply.)

General

- Fever
- Chills
- Night Sweats
- Trouble Sleeping
- Loss of Appetite
- Weight Loss
- Weight Gain

Head/Eyes

- Dizziness
- Headache
- Use of Glasses
- Loss of Vision
- Blurry Vision

Ear, Nose, Throat

- Loss of Hearing
- Hearing Aid
- Ringing in Ears
- Nose Bleeds
- Sinusitis
- Sore Throat
- Swollen Glands

Respiratory

- Asthma/Wheezing
- Difficulty Breathing
- Shortness of Breath
- Coughing

Cardiac

- Chest Pain
- Palpitations
- Chest Pressure

Gastrointestinal

- Trouble Swallowing
- Nausea/Vomiting
- Acid Reflux
- GI Ulcer
- Abdominal Pain
- Constipation
- Diarrhea
- Rectal Bleeding

Genitourinary

- Urinary Tract Infection
- Burning
- Blood
- Pain
- Frequency
- Incontinency
- Testicular Pain
- Irregular Periods
- Abnormal Discharge

Musculoskeletal

- Joint Swelling
- Back/Neck Pain
- Hip/Thigh Pain
- Joint Stiffness
- Bone or Joint Infection
- Calf Pain
- Leg Cramping when walking
- Tendonitis
- Dislocations

Neurological

- Fainting
- Seizures
- Numbness
- Tingling
- Abnormal Sensations
- Tremors
- Muscle Weakness
- Muscle Paralysis
- Stroke

Dermatological

- Rashes
- Ulcers
- Sores
- Infection
- Abnormal Discoloration
- Peeling Skin

Psychological

- Nervousness
- Depression
- Bipolar
- Anxiety
- Memory Loss
- Confusion
- Insomnia

Lymphatic

- Leg Swelling
- Swollen Nodes
- Red Streaking (Angitis)

The above referenced ROS was reviewed with the patient: _____ DPM

Statement of Fact/Consent to Treatment: I have completed this form fully and to the best of my knowledge. I understand that it is my responsibility to inform the doctor with regards to any changes in my medical history, medications, and medical coverage prior to any follow up visits. I hereby consent to evaluation and treatment of my current condition which includes physical examination and use of instrumentation to help diagnose and treat my current problem.

Signature: _____ Date: _____

INSURANCE CERTIFICATION AND ASSIGNMENT

Insurance Assignment: I hereby request and assign all medical and surgical benefits to which I am entitled including Medicare, Medigap carrier, Private Insurance, HMO, PPO, Worker's Compensation, and any and all other health insurance plans be made directly payable to Dr. David Gannon and Shore Foot & Ankle for any services and medical supplies furnished to me by this office. I authorize any holder of medical information about me to the health care financing administration and its agents needed to determine these benefits or the benefits payable for related services. I understand that even though I have some type of health care insurance that I am ultimately responsible for payments for services and supplies rendered by Dr. David Gannon and Shore Foot & Ankle. I authorize release of my medical information from this office to other health care providers. I understand that I am financially responsible for all co-payments, deductibles, and balances for services rendered, as well as, a 1.5% interest charge on any unpaid patient responsibility balance over 120 days. A copy of this signature is as valid as the original.

Signature: _____ Date: _____

Insurance Certification and Waiver: I certify that I am the person so indicated on the insurance card or the duly authorized agent of the patient authorized to furnish the information requested. I fully understand that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. I have provided my health insurance information so that Dr. David Gannon and Shore Foot & Ankle may bill my insurance for services rendered to me. I understand my responsibility to pay any co-payments, deductibles, and balances not paid by my insurance at the time of service. I understand that I am subject to the coverage benefits of my health insurance program and may not be covered for all services under my plan. I understand that if my insurance requires referrals and authorization for services that it is the patient themselves or their Primary Care Physicians that are responsible for getting the authorized referrals for care and payment. I understand that I am financially responsible for any care rendered to me. At which time when a non-covered service is provided, I understand I am solely responsible for these charges incurred and issue this waiver to exempt my insurance from any responsibility for payment of such services rendered.

Signature: _____ Date: _____

ERISA Assignment: ERISA is an acronym for the Employee Retirement Income Security Act which includes federal laws requiring insurance companies to process submitted insurance claims according to ERISA regulations. In the event my insurance plan refuses to pay for medically reasonable and necessary services provided, I assign all my ERISA rights to Dr. David Gannon and Shore Foot & Ankle for a full and fair review of any and all denied claims, including penalties that may be assessed against the insurance company for claims-processing violations. I understand that I am responsible for the normal co-payment as required by my insurance carrier. I assign the payment of all benefits and penalties to Dr. David Gannon and Shore Foot & Ankle. I consent to release all information necessary by Dr. David Gannon and Shore Foot & Ankle for resolution of unpaid service disputes.

Signature: _____ Date: _____

(Please complete other side of page)

SHORE FOOT & ANKLE

SUMMARY OF NOTICE OF PRIVACY PRACTICES

This summary is provided to assist you in understanding the attached Notice of Privacy Practices

The attached Notice of Privacy Practices contains a detailed description of how our office will protect your health information, your rights as a patient and our common practices in dealing with patient health information. Please refer to that Notice for further information.

Uses and Disclosures of Health Information. We will use and disclose your health information in order to treat you or to assist other health care providers in treating you. We will also use and disclose your health information in order to obtain payment for our services or to allow insurance companies to process insurance claims for services rendered to you by us or other health care providers. Finally, we may disclose your health information for certain limited operational activities such as quality assessment, licensing, accreditation and training of students.

Uses and Disclosures Based on Your Authorization. Except as stated in more detail in the Notice of Privacy Practices, we will not use or disclose your health information without your written authorization.

Uses and Disclosures Not Requiring Your Authorization. In the following circumstances, we may disclose your health information without your written authorization:

- To family members or close friends who are involved in your health care;

- For certain limited research purposes;
- For purposes of public health and safety;
- To Government agencies for purposes of their audits, investigations and other oversight activities;
- To government authorities to prevent child abuse or domestic violence;
- To the FDA to report product defects or incidents;
- To law enforcement 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 law.

Patient Rights. As our patient, you have the following rights:

- To have access to and/or a copy of your health information;
- To receive an accounting of certain disclosures we have made of your health information;
- To request restrictions as to how your health information is 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.

If you have a question, concern or complaint regarding our privacy practices, please refer to the attached Notice of Privacy Practices for the person or persons whom you may contact.

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 had the opportunity to read and understand the notice. I understand that I can request a copy of a summary of the privacy practices, a full printed copy, or may review the privacy practices on the website at www.shorefootandankle.com.

Signature: _____

Date: _____