JENISON PODIATRY PATIENT FORM

PATIENT INFORMATION

Today's Date:_____

Name (First, Middle, Last):_____ DOB: _____ AGE_____

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

Home phone: _____ Cell: _____ Work:_____

Employer:_____ Occupation: _____

Sex: _____ Marital Status _____ E-Mail Address: _____

Whom may we thank for referring you: _____

Emergency Contact: _____ Relationship: _____

Contact's phone: _____ Student: Yes No *if yes.... Part time____ Full time____

If student, parent's address: _____

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OTHER INFORMATION

Primary Care Physician: _____ Phone: _____

If you have been to your PCP in the past year, why:_____

Previous Surgical History: _____

Previous Podiatric History: _____

Describe your foot problem: _____

When did symptoms start: _____ Which foot is affected: Right___ Left____ Both ____

How have you treated this: _____

What medications are you now taking: **If you have a medication list, please show our staff and we can make a copy for you*

_____

Are you pregnant: Yes ____ No ____ Possibly ____ Last tetanus shot _____ Shoe size _____

Height: _____ Weight: _____ Daily tobacco use _____ Weekly alcohol use _____

Previous substance abuse: _____

ALLERGIES

I have no allergies to the best of my knowledge ____

I am allergic to the following:

____Adhesives/Tapes	____Demerol	____Novacaine	____Sutures
____Antihistamines	____Indocin	____Nylon/Plastic	____Other (List below)
____Aspirin	____Iodine	____Penicillin	_____
____Codeine	____Keflex	____Sulfa	_____

If allergic, what type of reaction:_____

DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING:

____Anemia	____Gout	____Low back pain
____Arthritis	____Hardening of arteries	____Nervousness
____Asthma	____Heart problem	____Phlebitis/Blood clot
____Bleeding tendency	____Hepatitis	____Infections
____Cancer	____High blood pressure	____Rheumatic fever
____Diabetes	____Joint pain	____Stomach problems
____Dementia/Alzheimer	____Kidney problems	____Stroke
____Dizziness/Fainting	____Liver problems	____Thyroid problems
____Epilepsy	____Lung problems	____Unequal leg length
____Glaucoma	____Foot skin problems	____Varicose veins
____Bunions	____Swelling feet/ankles	____Weak ankles
____Foot/Leg cramps	____Toenail problems	____Weak ankles
____Foot/Leg numbness	____Knee pain	

History of major medical conditions in immediate family members: (ex: diabetes, heart, cancer)

_____

Is there anything else we should know: _____

I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ANY CHARGES INCURRED OR BALANCE DUE FOR SERVICES PROVIDED BY DR. GENE OOSTERHOUSE ON DATE OF SERVICE.

Signature:_____ Date:_____

JENISON PODIATRY, P.C.

I understand that, under the Health Insurance portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly,
Obtain-payment from third-party payers,
Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your Notice of Privacy Practices containing a more complete Description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Private Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions but if you do agree then you are bound to abide by such restrictions.

RELEASE OF INFORMATION

I authorize the release of information including the diagnosis, records; examination rendered to me and information in regard to billing and payment information.

___ Spouse _____

___Child(ren)_____

___Other _____

___Information is NOT to be released to anyone.

____I also authorize Jenison Podiatry, when contacting you in reference to your appointment, to speak to the person answering your telephone with your appointment information, or, leave a message regarding your appointment on your answering machine.

*This release of information will remain in effect until terminated by me in writing.

_____ _____

PRINTED name of patient or personal representative relationship to patient

_____

SIGNATURE of patient or personal representative

Date _____