Mulberry Foot Care, LLC   1620 Mulberry Street   Montgomery AL 36106

Office: 334-239-7335   Fax: 334-239-7118   Date ____________

Patient____
Last name   First name   Initial   Name (preferred to be called)

Responsible Party: Self or Other (please specify) ____

Street Address__________________________ City______________ State______ Zip Code______________

Home Phone___________________________   Cell Phone___________________________________

Birthdate__________________ Age_______ Sex M F   Single Married Widowed Separated Divorced

Social Security #_______________Emergency Contact_____________________ Phone__________________

I give Mulberry Foot Care, LLC permission to release my medical records to the following individual:

1_________________________ 2_______________________ 3______________________________

May we leave messages on your answering machine (YES/NO)

Primary Care Physician _________________________________   Last Visit___________________________

Referred to our practice by_______________________ Heard about our practice by_______________________

Employer___________________________ Work Phone____________ Position/Occupation_______________

Financial Information

PLEASE PROVIDE ALL YOUR INSURANCE CARDS TO THE RECEPTIONIST TO BE COPIED

Name of Insured (if not patient):__________________________ Relationship to patient:______________________

Date of Birth (Insured)____________ Phone____________ Social Security Number (Insured):________________

Primary Insurance Policy Holder________________   **Secondary Insurance** Policy Holder Name______________

Primary Insurance Company__________________   **Secondary Insurance** Policy Holder Name______________

Primary ID/Contract #________________________   **Secondary Insurance** ID/Contract #__________________

Primary Insurance Group/Plan #________________   **Secondary Insurance** Group Plan #___________________

****Please understand that you are responsible for all copays, deductibles, and other amounts deemed your responsibility by your insurance company. Some services may not be covered by your insurance plan. It is your responsibility to obtain information about covered services.**

MEDICAL HISTORY

CHIEF CONCERN/PRESENT ILLNESS:

What is your present foot problem?____

If due to injury, date and details?____

____

How long you been bothered by the above?____

What have you done for your foot problem?____

____

Have you had previous foot care? If so, by whom:____

Are you now or have you been under a physician's care during the past two years? (circle one) Yes No

ALLERGY to any medications? (Please check all that apply): ____Adhesive Tape ___ Amoxicillin _____ Aspirin

____ Augmentin ____ Betadine ____ Codeine ____ Demerol ____ Erythromycin ____ Ibuprofen ____ Iodine

____ Keflex ____ Latex ____ Morphine ____ NSAIDs ____ Penicillin ____ Sulfa Drugs ____ Tylenol

____ Novocain _____ Antihistamines Other____

****What type of allergic reaction do you have to the medicine?**____

MEDICATION Are you presently taking any medicine? (circle one) Yes No If yes, what?_______________________

____

Pharmacy Name and Phone Number ____

PAST MEDICAL HISTORY (Circle if you now have or were ever treated for):

HIV/AIDS	Bleeding tendency	Heart Disease	Mitral Valve Prolapse
Allergies	Cancer____________	Heart Murmur	Mental health conditions
Anemia	Diabetes Type_______	Hepatitis	Rheumatic Fever
Anesthesia Problems	Epilepsy	High Blood Pressure	Tuberculosis
Arthritis	Glaucoma	Kidney Disease	Foot Ulcers
Asthma	Gout	Liver Trouble	Circulation Disorders
Stomach Ulcer	Polio	Venereal Disease	Leg Cramps

Stroke Previous Foot Conditions ______________________ Other Medical Issues____________________

Have you had SURGERY? (circle one) Yes or No

TYPE OF SURGERY YEAR

____ _____________

____ ___________

Social History

Use of Alcohol: Never Rarely Moderate Daily Quit _________
Use of Tobacco: Never Quit:________ Current packs/day_________ **Use of Drugs**: Never Type/frequency:___________

FAMILY HISTORY (Circle if any blood relatives have had) Indicate M (Mother) F (Father) S (Siblings)

	M	F	S		M	F	S
Arthritis				High Blood Pressure			
Cancer				Kidney Disease			
Diabetes				Overweight			
Heart Disease				Similar Foot Problems			

REVIEW OF SYSTEMS: (Please indicate current health status below by **circling** existing conditions)

CONSTITUTIONAL SYSTOMS
Good general health lately
Recent Weight Change
Fever
Fatigue
Pregnancy/Breast Feeding

GASTROINTESTINAL
Loss of appetite
Nausea or vomiting
Frequent diarrhea
Stomach Ulcers (GERD)

NEUROLOGICAL
Frequent or recurring headaches
Light headed or dizziness
Convulsions or seizures
Numbness or tingling sensations
Tremors
Paralysis
Head injury
Stroke

EYES
Eye disease or injury
Wear glasses/contact lenses

GENITOURINARY
Kidney disease
Dialysis
Kidney stones

CARDIOVASULAR
Chest pain or angina pectoris
Palpitation
Shortness of breath walking or lying flat
Swelling of feet, ankles or hands

MUSCULOSKELETAL
Joint pain
Joint stiffness or swelling
Weakness in muscles or joints
Muscle pain or cramps
Back pain
Cold extremities
Difficulty in walking
Neuromuscular disease

PSYCHIATRIC
Blurred or double vision
Memory loss or confusion
Depression
Insomnia

ENDOCRINE
Diabetes
Glandular or hormone problem
Excessive thirst or urination
Heat or cold intolerance
Skin becoming dryer
Chronic or frequent coughs

HEMATOLOGIC/LYMPHATIC
Slow to heal after cuts
Bleeding or bruising tendency
Anemia
Phlebitis
Past transfusion
Enlarged glands

RESPIRATORY
Spitting up blood
Shortness of breath
Wheezing

INTEGUMENTARY (SKIN)
Rash or itching
Change in skin color
Change in hair or nails
Varicose Veins

I have reviewed with the patient complete history provided: ______________ Ace Irvin Anglin, DPM Date ______

Privacy and Consent Information

AUTHORIZATION FOR TREATMENT, ASSIGNMENT AND RELEASE

I hereby give Mulberry Foot Care, LLC and its staff member's permission to treat my feet and/or ankle disorders. I, the undersigned, have insurance coverage with ____ and assign directly to Mulberry Foot Care, LLC all medical 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 insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions.

____ ____________________________________

Signature of Insured/Guardian Date

MEDICARE AUTHORIZATION

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Mulberry Foot Care; LLC for any services furnished me by that physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

____ ______________________________________

Beneficiary Signature/Guardian Date

NOTICE OF PRIVACY PRACTICES – ACKNOWLEDGEMENT OF RECEIPT

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

____ _______________________________________

Patient Signature/Guardian Date