

PATIENT INFORMATION FORM

Date: ___/___/___

Patient Name: _____
Last First MI

Date of Birth: ___/___/___ Age: ___ Sex: Male/Female

Home Address: _____ City/State: _____ Zip: _____

Home Telephone Number:(____) _____ - _____ Work Telephone Number:(____) _____ - _____

Cell Telephone Number:(____) _____ - _____ E-Mail _____

Social Security Number: _____ - _____ - _____ Primary Language: _____

Do you have a legal guardian or a healthcare power of attorney? Yes/No

-Name: _____ Relationship: _____ Telephone Number:(____) _____ - _____

Employer: _____ Telephone Number: (____) _____ - _____

Emergency Contact: _____ Relationship: _____ Telephone Number:(____) _____ - _____

Primary Care Provider: _____ Provider Telephone Number:(____) _____ - _____

Provider Fax Number:(____) _____ - _____ Date of last visit with your primary care provider: ___/___/___

Pharmacy: _____ Address: _____ Telephone Number:(____) _____ - _____

Is there a family member or another person you would like for us to share your medical information? Yes/No

-Name: _____ Relationship: _____ Telephone Number:(____) _____ - _____

Who is responsible for payment? _____ Relationship: _____ Telephone Number:(____) _____ - _____

-Home Address: _____ City/State: _____ Zip: _____

Insurance Information

Primary Insurance Company Name: _____ Telephone Number:(____) _____ - _____

Address: _____ City/State: _____ Zip: _____

Insured Name: _____ Date of Birth: ___/___/___ Employer: _____

Member/Policy Number: _____ Group Number: _____

Secondary Insurance Company Name: _____ Telephone Number:(____) _____ - _____

Address: _____ City/State: _____ Zip: _____

Insured Name: _____ Date of Birth: ___/___/___ Employer: _____

Member/Policy Number: _____ Group Number: _____

Please list all medications you are currently taking, including over-the-counter prescriptions and herbal supplements:

Name	Dose	How often do you take
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

List all prior surgeries:

Type of Surgery	Surgery Date
_____	_____
_____	_____
_____	_____

List all prior hospitalizations, other than surgery:

Reason for Hospitalization	Hospitalization Date
_____	_____
_____	_____
_____	_____

Social History

Marital Status: *Single *Married *Divorced *Widowed

Use of Alcohol: *Yes/No *No longer use *History of Alcohol Abuse: _____

-Current Use-Type: _____ *Occasional *Daily

Use of Tobacco: *Yes/No *No longer use *Smoke-How many cigarettes per day? _____

Use of Recreational Drugs: *Yes/No *No longer use *How long ago did you quit? _____

-Current Use-Type: _____ *Occasional *Daily

Exercise: *Yes/No *Occasional *Daily *Type of Exercise: _____

Family History

Do you have a family history of: *Diabetes *Cancer *Heart Disease *High Blood Pressure *Stroke

*Thyroid Disease *Rheumatoid Arthritis *Coronary Artery Disease *Other: _____

Your Medical History

Allergies: (None) Medications: _____ Anesthesia: _____

Latex: _____ Foods: _____

Iodine: _____ Other: _____

Have you ever had any of the following:

- | | | |
|-------------------------------|--------------------------------|------------------------------|
| -Acid Reflux: Yes/No | -Gout: Yes/No | -Open Sores: Yes/No |
| -Anemia: Yes/No | -Heart Attack: Yes/No | -Pneumonia: Yes/No |
| -Arthritis: Yes/No | -Heart Disease/Failure: Yes/No | -Polio: Yes/No |
| -Asthma: Yes/No | -Hepatitis: Yes/No | -Rheumatic Fever: Yes/No |
| -Back Trouble: Yes/No | -HIV+/Aids: Yes/No | -Sickle Cell Disease: Yes/No |
| -Bladder Infections: Yes/No | -High Blood Pressure: Yes/No | -Skin Disorder: Yes/No |
| -Abnormal Bleeding: Yes/No | -Kidney Disease: Yes/No | -Sleep Apnea: Yes/No |
| -Blood Clots: Yes/No | -Liver Disease: Yes/No | -Stomach Ulcers: Yes/No |
| -Bronchitis/Emphysema: Yes/No | -Low Blood Pressure | -Stroke: Yes/No |
| -Cancer: Yes/No | -Migraine Headaches: Yes/No | -Thyroid Disease: Yes/No |
| -Diabetes: Yes/No | -Mitral Valve Prolapse: Yes/No | -Tuberculosis: Yes/No |
| -Fibromyalgia: Yes/No | -Neuropathy: Yes/No | -Other: _____ |

List any symptoms you have had or are currently experiencing, including:

*Head, Eyes, Ears, Nose, and Throat: _____

*Respiratory: _____

*Cardiovascular/Hematologic: _____

*Gastrointestinal: _____

*Genitourinary: _____

*Musculoskeletal: _____

*Neurologic: _____

*Skin: _____

*Psychological: _____

Lakewood Foot & Ankle Specialists
Dr.Patrick Wylie Burge & Dr.Courtney McClurkin

Privacy Consent and Acknowledgment of Medical Privacy Notice

This consent is required by the Health Insurance Portability and Accountability Act of 1996 to inform you of your rights for privacy with respect to your health care information.

Consent for Care: I, with my signature, authorize Lakewood Foot and Ankle Specialists and any employee working under the direction of the physician, to provide medical care for me, or to this patient for which I am the legal guardian. This medical care may include services and supplies related to my health (or the identified person) and may include (but limited to) preventative, diagnostic, palliative care, counseling, surgical, dispensing of drugs, devices, equipment or other items required and in accordance with a prescription. This consent includes contact and discussion with other health care professionals for care and treatment.

Consent for Release of Information: I also authorize this practice to furnish information of the identified insurance carrier(s) for any and all payment activities. I further consent to the use for any practice operational needs and identified in the Medical Privacy Notice.

Consent for The Assignment of Benefits: I consent to assign all payments for these services to this practice. **I understand that I am responsible for all co-payments, amounts applied to deductibles and any co-insurance amounts, as required by my contract with my insurance plan and state regulation.** I further understand that my contract with my insurance entity may or may not cover some services. It is my responsibility to obtain information from my health plan about service coverage. If I seek care outside of the contract, I am aware that I may be responsible for all charges that are incurred.

Consent and Acknowledgement of Medical Privacy Notice: I have had a chance to review the Medical Privacy Notice as part of this registration process. I understand that the terms of the Privacy Notice may change and I may obtain these revised notices by contacting the practice by phone or in writing. I understand that I have the right to request how my protected health information (PHI) has been disclosed. I also have the right to restrict how this information is disclosed, but this use, practice it is bound is not required to agree to my restrictions. If it does agree to my restrictions on PHI by that agreement.

Patient/Guardian Signature: _____ **Date:** ___ / ___ / ___

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Financial Policy

When you do not show up for a scheduled appointment, it creates an unused appointment slot that could have been used for another patient. It is very important that you call 24 hours in advance to cancel your appointment. If for any reason you need to cancel or reschedule an appointment, please notify our office as a soon as possible.

- ★ Patients who arrive after 15 minutes from their scheduled appointment will be asked to either reschedule or wait until the schedule permits them to be seen. The patient will be responsible for a \$25.00 late fee charge to their account.

- ★ Patients who cancel or reschedule their appointments on the same day will be responsible for an additional \$50.00 fee to their account. This charge must be paid prior to scheduling another appointment.

- ★ Patients who do not call, “No Show”, for their appointment will be responsible for an additional \$50.00 fee to their account. This charge must be paid prior to scheduling another appointment.

- ★ A credit card is required to be stored on file for all patients and may be charged for any of the above circumstances.

Please note that if this happens more than 3 times, additional charges will be added to the patient's account, and/or the providers may eliminate the patient’s relationship with our clinic.

Patient/Guardian Signature: _____ **Date:** ___/___/___

To the best of my knowledge, I have answered the questions on this form accurately. I understand that providing incorrect information can be dangerous to my health. I understand that it is my responsibility to inform the providers and office staff of any changes made to my medical status.

Print Name of Patient, Parent or Guardian

Signature of Doctor

Relationship to Patient

Date

Signature