BRONDON FOOT AND ANKLE

(937) 433-0444 or (513) 342-1907

420 Miamisburg-Centerville Rd., Centerville,OH * 27 Indiana St., Monroe, OH

Patient Information

Name:_____ Date of Birth: _____ Age:_____
Address:_____City, State: _____Zip:_____
Primary Phone Number: _____ □Home □Cell □Work
Secondary Phone Number: _____ □Home □Cell □Work Shoe Size:_____
SSN: _____ Email:_____ Height:_____ Weight:_____
Marital Status: □Single □Married □Divorced □Separated □Widowed
Employer: _____ Patient Occupation: _____

*If patient is under 18, we will need the following information from a parent or guardian:
Name:_____ Date of Birth: _____
SSN:_____ Relationship to Patient:_____
Phone (if different from patient): _____ □Home □Cell □Work
Address (if different from patient):_____

Referral Information: Who may we thank for referring you to us?
□Physician □Insurance Plan □Family/Friend □Yellow Pages □Google □Internet Website
□Walked By/Drove By □Former Patient □Other: _____

Primary Care Physician: To facilitate sharing of information related to your care, please provide the following:

Primary physician: _____ Office Phone Number: _____
Date of Last Visit? (approx): _____
Do You Reside in Hospice? Yes No
Do You Reside in a Nursing Home? Yes No Name of Residence: _____

Emergency Contact

Name: _____ Relationship: _____
Phone Number: _____ □Home □Cell □Work

Insurance Information (If patient is not the primary cardholder.)

Primary Cardholder Name: _____ Date of Birth: _____
Relationship to patient: _____

Preferred Pharmacy: _____ Pharmacy Number: _____

What Brought You in Today?

What is the reason for your visit today? (Indicate foot, ankle, toe, etc.):_____

_____

How long has this been a problem? _____

How have you treated it?

_____

What makes it better/worse?

_____

Have you ever been to a podiatrist in the past? Yes No *If yes, please list the podiatrist:_____

_____

Lifestyle

What is your current smoking status? □Never Smoker □Former Smoker □Current smoker, _____ packs per day

Do you drink alcohol? □Yes □No Do you use recreational drugs? □Yes □No

Have you had a pneumonia shot in the last 5 years? □Yes □No Have you had a flu shot? □Yes, Year:_____ □No

Allergies - Please list any and all allergies that you have. Check none if you have no known allergies:

□None	□Adhesive/Tape	□Codeine	□Local Anesthetics	□Novocain
□Seafood	□Sulfa	□Aspirin	□Iodine	□Penicillin
□Seasonal/Pollen/Ragweed		□Other: _____		

Please indicate the severity of your reaction to each allergy indicated above (severe, mild, etc.):

_____

What happens with each allergic reaction? (skin rash, breathing problems, stomach ailments, etc.):

_____

Medical History - Please indicate if you have had any of the following conditions:

□Diabetes	□Osteoarthritis	□Heart Disease	□Asthma	□Hepatitis/Jaundice
□High Blood pressure	□Gout	□Stroke/Heart Attack	□Shortness of Breath	□HIV/AIDS
□High Cholesterol	□Back Problems	□Chest Pain	□Fainting/Dizziness	□Cancer
□Neuropathy	□Osteoporosis	□Circulation Problems	□Stomach ulcers	□Depression
□Foot/Leg ulcers	□Fibromyalgia	□Bleeding Disorders	□Headaches	□Melanoma
□Artificial Valves/Joints	□Kidney Disease	□Varicose veins	□Acid Reflux/GERD	

□Other: _____

Surgeries and Hospitalizations - Please list any/all major surgeries and hospitalizations that you have had:

_____

_____

Medications - Please list all medications/vitamins you currently take (unless you have provided a separate list)

□ I brought a list and gave it to the front desk. □ Not currently on any prescription or OTC medications/vitamins/supplements

_____

_____

_____

Family History- Are there any medical conditions that run in your family (cancer, heart problems, diabetes, etc)?

Mother _____ Father _____

Siblings _____ Children _____

Assignment & Release

□ Commercial Insurance Authorization

I, the undersigned certify that I (or my dependent) have insurance coverage with _____ and sign directly to Brondon Foot and Ankle all insurance 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 insurance submissions.

□ Medicare Authorization

I request that payment of authorized Medicare benefits be made on my behalf to Brondon Foot and Ankle for any services furnished to me by my 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 payable for related services. I understand my signature requests that payment be made and authorize release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA-1500 for, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes release for 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, 20%, and non-covered services. Coinsurance, 20% and the deductible are based upon the charge determination of the Medicare carrier.

_____ _____

Signature of patient OR responsible party if patient is under 18. Date

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Consent To Treat- I certify that the above information is true and correct to the best of my knowledge. I give permission to the doctor to administer and perform such procedures as may be deemed necessary in the diagnosis and/or treatment of my conditions. I give permission to acquire audiovisual documentation for diagnostic and treatment purposes. I understand that other practitioners such as surgical assistants, surgical residents, physician assistants, nurses and other staff may assist the doctor in performing my treatment and I give my permission for them to do so.

_____ _____

Signature of patient OR responsible party if patient is under 18. Date

Payment Policy & Privacy Practices

Notice of Privacy Practice

Health Information Use and Disclosure: Brondon Foot and Ankle understands that medical information about you and your health is personal and we are committed to protecting that information. With that understanding, we will use and disclose your health information expressly for the following purposes: to treat you, to assist other healthcare providers in treating you, to allow insurance companies to process claims for services rendered to you, to obtain payment for services rendered to you, and for certain limited operational activities, such as quality assessment, licensing, accreditation and training of students. Except for the aforementioned reasons, we will not use or disclose your health information without your written authorization. We reserve the right to change this notice and will post a copy of the current (dated) notices in effect in our facility. For more information, please ask the front desk for a detailed printed copy of our privacy practices.

Additional Disclosure Authority: In addition to the allowable disclosures described in the State of OH Privacy Practices, I hereby specifically authorize disclosure of my protected health care information to the person(s) indicated below. This can include: any/all members of immediate family, spouse, employer, school, or any other person.

_____ _____

Name & Relationship to Patient Name & Relationship to Patient

_____ _____

Name & Relationship to Patient Name & Relationship to Patient

Patient Rights

As our patient, you have the following rights:

- To have access to inspect and/or obtain a copy of your health records that may be used to make decisions about your care.
- To receive an accounting of certain health information disclosures we have made.
- To request restrictions pertaining to how health information is used and disclosed for treatment payment or health operations.
- To request that we communicate with you in confidence; in a certain way or at a certain location. For example, you can ask that we only contact you by mail or at work.
- To request that we amend your health information if you feel medical information we have about you is incorrect or incomplete.

Acknowledgement of Payment Policy/Notice of Privacy Practices

Payment Policy

I have read and fully understand the payment policy of Brondon Foot and Ankle as provided to me on the new patient clipboard. I acknowledge my rights and responsibilities and agree to act in accordance with the policy set forth. I understand that if I fail to comply with the policy, Brondon Foot and Ankle reserves the right to dismiss me from the practice. A paper copy will be provided to me upon request.

Privacy Practices

I acknowledge that a copy of the Notice of Privacy Practices and has been made available to me and I understand the Notice.

_____ _____

Signature of patient OR responsible party if patient is under 18. Date