TOWN CENTER FOOT CLINIC

Foot and Ankle Specialists

PAUL CLINT JONES, DPM | TRENT H. LOTT, DPM

PATIENT REGISTRATION FORM

(Confidential information – important for our files and for your health)

Patient name ______ Preferred name ______

Birth date ____ / ____ / ____ Age ____ ☐ Male ☐ Female Marital status ______

Mailing address ______ Preferred Phone ______

City ______ State ______ ZIP ______ Secondary phone ______

Email address ______

Employer ______ Phone ______

Is this a work-related injury? ☐ No ☐ Yes If so, has a claim been initiated? ☐ No ☐ Yes

Name & address of emergency contact ______

______ Phone ______

How did you find us? ***(Dr./Patient Referral)*** ***(Internet)*** ***(Insurance)*** ______

Whom may we thank for your referral to our clinic? ______

Who is financially responsible for any fees for services performed here after your insurance company has finished paying? ______

MEDICAL INSURANCE INFORMATION

(Please present your insurance card to the front desk)

1. Insurance name: ______ I.D.# ______

2. Additional coverage: ______ I.D.# ______

ASSIGNMENT OF BENEFITS

I authorize payment of medical benefits to the named provider(s) for professional services rendered.

Sign ______

Date ______

RELEASE OF INFORMATION

I authorize the release of any medical information to process this claim.

Sign ______

Date ______

for office use only:

Photo ID checked ______

MEDICAL HISTORY & INFORMATION

Date of Birth

Please state current foot or ankle problem:

N/A List any surgeries or major procedures you have had, **including all body parts:**

Year	Surgery/procedure

N/A List any **MAJOR INJURIES** or **FRACTURES** you have had:

Year	Injury/fracture

N/A **REACTION?** CHECK ANY **ALLERGIES:** **REACTION?**

- Penicillin
- Sulfa
- Antibiotic:
- Iodine
- Adhesive tape
- Anti-inflammatories *(e.g. ibuprofen)*
- Pain medication:
- Others:
- Latex
- Novocaine
- Anesthetic:

N/A List **CURRENT MEDICATIONS:**

Name	Dose	Frequency	What for

Do you take aspirin on a daily basis? Yes No

If you take any herbal medications, list them here:

N/A **Past Medical History--Check any known medical conditions:**

- Arthritis
- Blood clots
- Diabetes BS/A1C
- History of MRSA *(Methicillin-Resistant Staph Aureus)*
- Heart condition
- High blood pressure
- Liver disease(Hep)
- Pregnancy (due date:)
- Respiratory problems
- Stomach problems
- Kidney disease
- Others:(HIV, Cancer, etc.)

SOCIAL HISTORY

Health Habits

Tobacco	Do you use tobacco? Yes No	
	If yes: how many packs/cans/day/week:	# years:
Alcohol	Do you drink alcohol? Yes No	
	If yes, what form and how often?	
Occupation		
Activity	How often are you on your feet daily?	10% 25% 50% 75% 90%

Family Medical History: List any significant health problem that your blood relatives have had (*for example*: **heart disease, diabetes, stroke, thyroid disease, cancer, arthritis, foot conditions, etc.**).

Check here if you are adopted or if you don't know your family medical history

N/A Significant **FAMILY HEALTH** problems

Mother	
Father	
Siblings	
(Maternal) Grandmother	
(Maternal) Grandfather	
(Paternal) Grandmother	
(Paternal) Grandfather	

N/A **SYSTEM SYMPTOMS** check any symptoms that you are currently experiencing

General	Fever	Chills	Recent weight change
Cardiovascular	Chest pain	Calf pain	Leg swelling
Respiratory	Shortness of breath	Cough	Wheezing
Head, eyes, nose, throat	Headaches	Blurred or double vision	Hay fever
Gastrointestinal	Heartburn/acid reflux	Nausea/vomiting	Abdominal pain
Skin	Rash	Open sores	Dry skin
Musculoskeletal	Joint pain	Back pain	Neck pain
Neurological	Tremors	Dizzy spells	Numbness or tingling
Endocrine	Excessive thirst	Too hot/cold	Fatigue/tired
Hematological	Easy bruising	Blood clotting problem	Anemia

HEIGHT: **WEIGHT:** **SHOE SIZE:**

Primary care physician

Address

Phone Date of last visit to physician

Protecting Your Confidential Health Information is Important to Us

To The U.S. Department of Health and Human Services (HHS)

We may disclose your health information to HHS, the government agency responsible for overseeing compliance with federal privacy law and regulations regulating the privacy and security of health information.

For Research
We may use or disclose your health information for research, subject to conditions. "Research" means systemic investigation designed to contribute to generalized knowledge.

In Connection With Your Death or Organ Donation
We may disclose your health information to a coroner for identification purposes, to a funeral director for funeral purposes, or to an organ procurement organization to facilitate transplantation of one of your organs.

If applicable State law does not permit the disclosure described above, we will comply with the stricter State law.

Authorization to Use or Disclose Health Information
We are required to obtain your written authorization in the following circumstances: (a)to use or disclose psychotherapy notes (except when needed for payment purposes or to defend against litigation filed by you); (b) to use your PHI for marketing purposes; (c) to sell your PHI; and (d) to use or disclose your PHI for any purpose not previously described in this Notice. We also will obtain your authorization before using or disclosing your PHI when required to do so by (a) state law, such as laws restricting the use or disclosure of genetic information or information concerning HIV status; or (b) other federal law, such as federal law protecting the confidentiality of substance abuse records. You may revoke that authorization in writing at any time.

PATIENT RIGHTS

You have the following rights related to your health information.

Restrictions
You have the right to request restrictions on the use or disclosure of your health information for treatment, payment, or healthcare operations in addition to the restrictions imposed by federal law. Our office is not required to agree to your request, unless (a) you request that we not disclose your PHI to a health insurance company, Medicare or Medicaid for payment or healthcare operations purposes; (b) you, or someone on your behalf, has paid us in full for the healthcare item or service to which the PHI pertains; and (c) we are not required by law to disclose to the insurer, Medicare, or Medicaid the PHI that is the subject of your request, but we will endeavor to honor reasonable requests. We generally are not required to agree to a requested restriction. Our office will honor your request that we not disclose your health information to a health plan for payment or healthcare operation purposes if the health information relates solely to a healthcare item or service for which you have paid us out-of-pocket in full.

Patient Acknowledgement

Patient Names(s)

Thank you very much for taking time to review how we are carefully using your health information. If you have any questions we want to hear from you. If not, we would appreciate very much your acknowledging your receipt of our policy by signing this form

Patient Signature

Date / /

For additional information about the matters discussed in this notice, please contact our Privacy Officer

Confidential Communications
You have the right to request that we communicate with you by alternative means or at an alternative location. You may, for example, request that we communicate your health information only privately with no other family members present or through mailed communications that are sealed. We will honor your reasonable requests for confidential communications.

Inspect and Copy Your Health Information
You have the right to read, review, and copy your health information, including your complete chart, x-rays and billing records. If you would like a copy of your health information, please let us know. We may need to charge you a reasonable, cost-based fee to duplicate and assemble your copy. If there will be a charge, we will first contact you to determine whether you wish to modify or withdraw your request.

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Amend Your Health Information
You have the right to ask us to update or modify your records if you believe your health information records are incorrect or incomplete. We will be happy to accommodate you as long as our office maintains this information. In order to standardize our process, please provide us with your request in writing and describe the information to be changed and your reason for the change.

Your request may be denied if the health information record in question was not created by our office, is not part of our records or if the records containing your health information are determined to be accurate and complete. If we deny your request, we will provide you with a written explanation of the denial.

Accounting of Disclosures of Your Health Information
You have the right to ask us for a description of how and where your health information was disclosed. Our documentation procedures will enable us to provide information on health information disclosures that we are required to disclose to you. Please let us know in writing the time period for which you are interested. Thank you for limiting your request to no more than six years at a time. We will provide the first accounting during any 12-month period without charge. We may charge a reasonable, cost-based fee for each additional accounting during the same 12-month period. If there will be a charge, the Privacy Official will first contact you to determine whether you wish to modify or withdraw your request.

Request a Paper Copy of this Notice
You have the right to obtain a copy of this Notice of Privacy Practices directly from our office at any time. Stop by or give us a call and we will mail or email a copy to you.

Receive Notice of a Security Breach
You have the right to receive notification of a breach of your unsecured health information.

Changes to the Notice
We are required by law to maintain the privacy of your health information and to provide to you or your personal representative with this Notice of our Privacy Practices. We are required to practice the policies and procedures described in this notice but we do reserve the right to change the terms of our Notice. If we change our privacy practices we will be sure all of our patients receive a copy of the revised Notice.

Complaints
You have the right to express complaints to us or to the Secretary of Health and Human Services if you believe your privacy rights have been compromised. We encourage you to express any concerns you may have regarding the privacy of your information. We will not retaliate against you for submitting a complaint. Please let us know of your concerns or complaints in writing by submitting your complaint to our Privacy Officer.

Effective Date: 9/23/2013

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We may disclose your health information to HHS, the government agency responsible for overseeing compliance with federal privacy law and regulations regulating the privacy and security of health information.

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