

Affiliated Podiatry Group

Dr. Jameson B. Noorda • Dr. Tracy K. Leavitt • Dr. Spencer K. Noorda

Patient Information

Patient Name: First _____ Middle Initial _____ Last _____
Mail Address _____ Apt# _____ City _____ State _____ Zip _____
Home Phone _____ Cell Phone _____ Birth Date _____
Age _____ Sex _____ Marital Status _____ Social Security Number _____
Responsible Party _____
Email address _____

Information has not changed since last time filling out a patient information sheet.

Primary Insurance

Primary Insurance Company _____
Insured's Name _____ SS# _____ Birth Date _____
Insured's
Employer _____ ID# _____ Group# _____

Secondary Insurance

Secondary Insurance
Company _____
Insured's Name _____ SS# _____ Birth Date _____
Insured's Employer _____ ID# _____ Group# _____

**Primary Care Physician _____ Phone: _____ Fax: _____

Are you currently pregnant? No _____ Yes _____ How many weeks _____

Please mark to indicate if you have had any of the following problems:

<input type="checkbox"/> Diabetes	<input type="checkbox"/> Heart Disorders	<input type="checkbox"/> Recent Weight Loss
<input type="checkbox"/> Allergies/Hay fever	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Scaring Tendency
<input type="checkbox"/> Anemia	<input type="checkbox"/> HIV	<input type="checkbox"/> Shortness of breath
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Joint Pain / Stiffness	<input type="checkbox"/> Skin Disorders
<input type="checkbox"/> Asthma	<input type="checkbox"/> Kidney Disorders	<input type="checkbox"/> Stomach Disorders
<input type="checkbox"/> Bleeding Tendency	<input type="checkbox"/> Leg Pain	<input type="checkbox"/> Strokes
<input type="checkbox"/> Chest Pain	<input type="checkbox"/> Liver Disease/Jaundice	<input type="checkbox"/> Swelling in feet/ankles
<input type="checkbox"/> Circulation Problems	<input type="checkbox"/> Lower Back Pain	<input type="checkbox"/> Thyroid Disorders
<input type="checkbox"/> Fainting or Convulsions	<input type="checkbox"/> Lung Disorder	<input type="checkbox"/> Trouble with hearing
<input type="checkbox"/> Gout	<input type="checkbox"/> Numbness in feet / legs	<input type="checkbox"/> Trouble with vision
<input type="checkbox"/> Headaches	<input type="checkbox"/> Psychiatric Disorders	<input type="checkbox"/> Other _____
		<input type="checkbox"/> None of the above

***PLEASE FILL OUT BACK OF THIS SHEET

Medical History

Are you **ALLERGIC** to any medications? No _____ Yes _____

If so, please list _____

Social History

Do you smoke? No _____ Yes _____ (please circle) (every day some days former)

Do you drink alcohol? No _____ Yes _____ (please circle) (mild moderate everyday before bedtime)

Race: (Please circle) Caucasian African American Hispanic Asian Other: _____

Preferred Language (Please circle) English Spanish Other: _____

Have you ever used any illegal drugs (No Yes) If so which ones _____

Family History

Indicate which of your immediate relatives have had any of the following diseases:

Cancer _____ Diabetes _____ Heart Trouble _____

High Blood Pressure _____ Kidney Disease _____

Mental/ Emotional Disease _____ Stroke _____ Arthritis _____

REASON FOR YOUR VISIT TODAY:

Consent For Treatment

I agree to pay for all services at the time they are rendered, unless other arrangements have been made. I furthermore give my consent to Affiliated Podiatry to bill my insurance company and for them to be paid directly for services rendered. I understand that my agreement with the insurance company is between me and the insurance company and that my doctor will bill them as a courtesy to me. I understand that I will be held liable for all copay, deductible, and coinsurance amounts. I further understand that I am responsible for any unpaid balance on my account. **I also understand that it is my responsibility to ensure that the doctor I see is a provider for my insurance and that I can be held responsible if he is not.** If collection fees are required, I agree to pay all legal and collection fees which are incurred. I hereby give my permission to Affiliated Podiatry to administer treatment and to perform minor operative procedures as may be deemed necessary in the diagnosis and treatment of my foot condition.

Signed _____ Witness _____
Patient Signature

Date _____

HIPAA Privacy Policy

I acknowledge that I have read and understand Affiliated Podiatry's "Access Authorization Policy". I further understand that I may receive my own copy upon my request.

Signed _____ Witness _____
Patient Signature

Date _____

CONSENT TO DISCUSS PATIENT INFORMATION

Federal Regulation defined under the Health Insurance Portability and Accountability Act (HIPAA), as amended, does not allow the physicians or their staffs to release, discuss, or otherwise disclose protected patient information without the express written consent of you, the Patient. If you would like this office to be able to discuss your medical care with someone other than yourself, please list the names of the individuals below. Persons on this list must provide their own identification and be able to verify your date of birth as a measure of added security before the release of any information.

PLEASE NOTE: YOUR SPOUSE AND/OR CHILDREN ARE NOT AUTOMATICALLY ALLOWED ACCESS TO YOUR RECORDS UPON REQUEST WITHOUT A WRITTEN POWER OF ATTORNEY OR WITH A COURT ORDER DECLARING THE PATIENT INCOMPETENT TO MAKE MEDICAL DECISIONS.

NAME OF PERSON ALLOWED ACCESS

RELATIONSHIP TO PATIENT

1. _____
2. _____
3. _____
4. _____

- _____
- _____
- _____
- _____

Patient Signature

Witness Signature

Date

