PARKWAY PODIATRY

"WE PUT YOUR FEET FIRST"

PATIENT INFORMATION		
FIRST NAME:	LAST NAME:	DOB:
CELL PHONE:	HOME PHONE:	EMAIL:
HOME ADDRESS:		
CITY:	STATE:	ZIP CODE:
SEX: MALE OR FEMALE	MARITAL STATUS: S M D W	

PRIMARY/DIABETIC DOCTOR INFORMATION		
PRIMARY DOCTOR:	PHONE:	LAST SEEN:
DIABETIC DOCTOR:	PHONE:	LAST SEEN:

PREFERRED PHARMACY	
NAME OF PHARMACY:	PHONE:
ADDRESS:	ZIP CODE:

EMERGENCY CONTACT	
FIRST NAME:	LAST NAME:
RELATIONSHIP	PHONE:

I THE UNDERSIGNED, AUTHORIZE Dr. Saphire/Dr. Rudowsky to examine and treat my feet and/or ankle medically, surgically, or biochemically. I hereby assign my insurance benefits to be paid directly to PARKWAY PODIATRY and I am responsible for any unpaid balance. I authorize the release of any medical information necessary to process all claims. I understand that I am responsible to pay any deductible and or copay due at time of my visit. I have received and read a copy of Parkway Podiatry's Notice of Privacy Practices. I am aware that Parkway

X _____ DATE: _____

Podiatry follows HIPPA regulations regarding the disclosure of any patient records and rights regarding my protected health information.

MEDICAL HISTORY								
WHAT BROUGHT YOU IN TO SEE THE DOCTOR?								
WHEN DID SYMPTOMS BEGIN?								
ALLERGIES:				HEIGHT:		WEIGHT:		
MEDICATIONS: WHAT MEDICATIONS ARE YOU CURRENTLY TAKING?								
MEDICATION	MG	MEDICATION	MG	MEDICATION	MG	MEDICATION	MG	

PAST MEDICAL HISTORY					
	YES	NO		YES	NO
HEART DISEASE			KIDNEY DISEASE		
HEART VALVE REPLACEMENT			FRACTURES		
HEART ATTACK			JOINT REPLACEMENT		
CHEST PAIN			ARTHRITIS		
PACEMAKER			GOUT		
HIGH BLOOD PRESSURE			FIBROMYALGIA		
HIGH CHOLESTEROL			OSTEOPOROSIS		
STROKE			LEG PAIN		
LIVER DISEASE			BACK PAIN		
LUNG DISEASE			WEAKNESS		
ASTHMA			NUMBNESS		
SLEEP APNEA			DIZZINESS		
HEPATITIS			MIGRAINES		
BLEEDING DISORDER			LOSS OF VISION		
CLOTTING			STOMACH ULCER		
ANEMIA			TUBERCULOSIS		

HIV			CANCER		
THYROID CONDITION			PREGNANT		
DIABETES TYPE 1 TYPE 2			SKIN CONDITIONS		

FAMILY HISTORY

	YES	NO		YES	NO
BLEEDING DISORDER			GOUT		
CANCER			ARTHRITIS		
HEART TROUBLE			BUNION		
HIGH CHOLESTEROL			FLAT FEET		
HIGH BLOOD PRESSURE			HIGH ARCHED FEET		
STROKE			PIGEON-FEET		
DIABETES					
OTHER:					

SOCIAL HISTORY

	YES	NO	HOW LONG? HOW OFTEN?WHAT KIND
DO YOU SMOKE?			
DID YOU EVER SMOKE?			
ALCOHOL USE			
ILLEGAL DRUG USE			

PAST SURGICAL HISTORY

PROCEDURE	DATE	COMPLICATION

SIGNATURE OF PATIENT (OR GUARDIAN) : _____ DATE:_____

In general, the HIPPA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's home.

I wish to be contacted in the following manner (check all that apply):

Home Telephone _____
O.K. to leave message with detailed information
Leave message with call-back number only

Work Telephone _____
O.K. to leave message with detailed information
Leave message with call-back number only

Written Communication
O.K. to mail to my home address
O.K. to mail to my work/office address
O.K. to fax to this number
Other

_____ _____
Patient Signature Date

_____ _____
Print Name Birthdate

The Privacy Rule generally requires healthcare providers to take reasonable steps to limit the use or disclosure of, and requests for PHI to the minimum necessary to accomplish the intended purpose. These provisions do not apply to uses or disclosures made pursuant to an authorization by the individual.

Healthcare entities must keep records of PHI disclosures. Information provided below, if completed properly, will constitute an adequate record.

Note: Uses and disclosures for TPO may be permitted without prior consent in an emergency.

Record of Disclosure of Protected Health Information

Date	Disclosed to Whom Address or Fax Number	(1)	Description of Disclosure/ Purpose of Disclosure	By Whom Disclosed	(2)	(3)

(1) Check this box if disclosure if authorized
(2) Type Key: T=Treatment Records; P=Payment Information; O=Healthcare Operations
(3) Enter how disclosure was made: F=Fax; P=Phone; E=Email; M=Mail; O=Other