PATIENT INFORMATION

(PLEASE PRINT)

First_____ MI_____ Last Name_____

Sex_____ SSN _____ Date of Birth_____ Age_____ Ht _____ Wt _____

Email Address _____

Address_____Apt#_____

City_____ST_____Zip_____

Home #_____ Work #_____ Cell #_____

Primary Physician _____ Date last seen _____

Primary language _____ Race _____ Hispanic/Latino Y or N

Referred by _____

Emergency contact _____ Phone _____

Marital Status: (circle one) single / married / legally separated / divorced / widowed / partner

Student Status: (circle one) full time / part time / not a student

Employment Status: (circle one) full time / part time / not employed

Employer _____ Phone _____

Job title _____Address _____

City _____ State _____ Zip _____

INSURANCE

Primary Insurance _____ Policy Holder's Name_____

Relationship to patient_____ DOB_____SSN_____

Secondary Insurance _____ Policy Holder's Name_____

Relationship to patient_____ DOB_____SSN_____

CONTACT PREFERANCES

What phone number can our office staff use to contact you regarding your personal health information and appointments?

(circle one) home / work / cell

May we leave a message at this number? (circle one) Yes / No

Who may we discuss personal health information with? _____

Who may we discuss appointment information with? _____

I hereby give Valley Foot Surgeons permission to treat me or my dependents as necessary. I understand my insurance company may assist me in paying all medical costs, but I am ultimately responsible for all medical services rendered and, if necessary, I agree to pay all reasonable and customary collection fees and/or attorney's fees that may be incurred due to any delinquent accounts I may have. I authorize the release of any medical information necessary to process my claim to my insurance company. I also authorize payment of medical benefits to my physician, directly, for services rendered. I understand that I am financially responsible for my bill.

****As a courtesy, we will bill your insurance company for you****

Signature: _____ Date: _____

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MEDICAL HISTORY

Drug allergies_____

Medications_____

_____

Are you diabetic Y/N If yes, what type? _____ controlled/uncontrolled (circle one) Are you insulin dependant? Y/N

SOCIAL HISTORY:

Do you smoke tobacco? Y/N Did you smoke? Y/N How much?_____ How many years?_____
Do you drink alcohol? Y/N Did you drink? Y/N How much?_____ How many years?_____
Do you use illegal drugs? Y/N If yes, how often? _____

What is your chief complaint today?_____
Do you have foot/ankle pain? Y/N Where is your pain?_____
How long have you had pain?_____ When do you get the pain?_____
Any history of injury to this area? Y/N If yes, explain:_____
Any previous treatment? Y/N Treated by:_____
What treatment have you tried?_____

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

I _____ acknowledge that a copy of VALLEY FOOT
(Name of Patient)

SURGEONS 'Notice of Privacy Practices' is displayed in the office lobby. I am also aware that I may request a copy of the 'Notice of Privacy Practices' from any member of the office staff. This notice describes how RICHARD P. JACOBY, D.P.M., P.C. (dba. VALLEY FOOT SURGEONS) may use and disclose my protected health information, certain restrictions on the use and disclosure of my healthcare information, and rights I may have regarding my protected health information.

_____ _____
(Signature of Patient, or Personal Representative) (Date)

_____
(Relationship to Patient)