No. _____

ALBUQUERQUE ASSOCIATED PODIATRISTS

CONFIDENTIAL PATIENT INFORMATION

DATE: _____

AGE: _____

DOB: _____

Welcome To Our Office
(PLEASE PRINT)

Patient _____
(last name) (first name) (middle initial) (social security number)

☐ Single ☐ Married _____
husband's or wife's name (if minor, parent or guardian's name)

Address _____ Primary Phone _____ Cell _____

City _____ State _____ Zipcode _____

Height: _____ Weight: _____ Shoe Size: _____ Email: _____

Employed By _____ Occupation _____

Business Address _____ Phone _____
(street) (city) (zip code)

Spouse Employed By _____ Occupation _____

Business Address _____ Phone _____
(street) (city) (zip code)

Insurance Company Name(s) _____ **Policy No(s):** _____

Policy Holder's Name _____ **DOB** _____ **SSN** _____

In Case of Emergency Notify _____ Phone _____

Relationship _____ May we release your medical information? ◯ Yes ◯ No

Pharmacy Name _____ Phone _____

Address _____

Whom May We Thank For Referring You To This Office? Name _____

Address _____

Family Physician _____ Last Visit _____

Former Podiatrist _____ Last Visit _____

Last Physical Examination _____

Any Known Drug Allergies? _____

What medicines do you take? _____

CIRCLE ONE: ☐ American Indian or Alaska Native ☐ Asian ☐ Native Hawaiian or Pacific Islander
☐ Black/AfricanAmerican ☐ White ☐ Hispanic ☐ Other _____ ☐ Refuse

We are in the process of implementing ePrescribing in our practice.

ePrescribing is a federally mandated initiative that requires all physicians prescribe in this matter by 2012. ePrescribing software sends prescriptions over the internet to your pharmacy in a safe, secure way. ePrescribing also lets your doctor see important information like drug interactions and medication history.

The benefit to you:

- **Less confusion over handwritten prescriptions or unclear phone calls.**
- **Reduced possibility of medical errors.**
- **Less chance of adverse drug reactions.**
- **Fewer trips to drop off at the pharmacy.**
- **A safer, faster, easier way to get your prescriptions filled.**

Patient Consent

I agree that Albuquerque Associates Podiatry may request and use my prescription medication history from other healthcare providers or third party pharmacy benefit payors for treatment purposes.

_____ _____
Patient Signature **Date**

THANK YOU I hereby give my permission to administer treatment, and to perform such minor operative procedures as may be deemed necessary in the diagnosis and/or treatment of my foot condition. Additional consents may be required.

SIGNATURE X _____

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage with _____ _____ and assign directly to Dr. Mark Haas / Dr. Zachary M. Haas / Dr. Matthew D. Cobb / Dr. Haywan Chiu / Dr. Paul Whitehouse / Dr. Jose Hernandez Lingao 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 submission.

X _____

RESPONSIBLE PARTY SIGNATURE

Relationship _____ Date _____

MEDICARE AUTHORIZATION

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Dr. Mark Haas / Dr. Zachary M. Haas / Dr. Matthew D. Cobb / Dr. Haywan Chiu / Dr. Paul Whitehouse / Dr. Jose Hernandez Lingao for any services furnished me by that physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and it's agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in Item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of 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, and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

_____

Beneficiary Signature Date

ALBUQUERQUE ASSOCIATED PODIATRISTS

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL/PROTECTED HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Summary:
By law, we are required to provide you with our Notice of Privacy Practices (NPP). This Notice describes how your medical information may be used and disclosed by us. It also tells you how you can obtain access to this information.

As a patient, you have the following rights:

1. The right to inspect and copy your information;
2. The right to request corrections to your information;
3. The right to request that your information be restricted;
4. The right to request confidential communications;
5. The right to a report of disclosures of your information; and
6. The right to a paper copy of this Notice.

We want to assure you that your medical/protected health information is secure with us. This Notice contains information about how we will insure that your information remains private.

If you have any questions or concerns about this Notice, please contact Albuquerque Associated Podiatrists at 505-247-4164.

Acknowledgement of Notice of Privacy Practices

"I hereby acknowledge that I have received a copy of this practice's **NOTICE OF PRIVACY PRACTICES.** I understand that if I have questions or complaints regarding my privacy rights that I may contact the person listed above. I understand that the practice will offer me updates to this **NOTICE OF PRIVACY PRACTICES** should it be amended, or changed in any way."

* I authorize my physician and his/her staff to contact me by the designated means noted below:
(Please check all that apply)

☐ Home Phone ☐ Home Answering Machine/Voice Mail ☐ Office/Work Place, Voice Mail ☐ Cell Phone/Voice Mail

* I authorize my physician and his/her staff to communicate information regarding appointments, medical results and billing issues to:
(Please print each name in this area)

☐ Spouse _____

☐ Others: _____, _____, _____

X _____ X _____ X _____

PATIENT OR REPRESENTATIVE NAME *(PLEASE PRINT)* | PATIENT OR REPRESENTATIVE SIGNATURE | DATE

☐ Patient refused to sign ☐ Patient was unable to sign because _____

Past Medical History Name_____Date_____

anemia	☐ Yes
arthritis	☐ Yes
arthritis, rheumatoid	☐ Yes
asthma	☐ Yes
AIDS/HIV	☐ Yes
autoimmune disorder	☐ Yes
cancer	☐ Yes
circulation disease	☐ Yes
deep vein thrombosis/blood clot	☐ Yes
Diabetes	☐ Yes
fibromyalgia	☐ Yes
foot ulcer	☐ Yes
gout	☐ Yes
herniated disc	☐ Yes
hypercholesterolemia	☐ Yes
hypertension	☐ Yes
kidney disease	☐ Yes
liver disease	☐ Yes
melanoma	☐ Yes
MRSA history	☐ Yes
myocardial infarction	☐ Yes
neuropathy	☐ Yes
osteoporosis	☐ Yes
raynauds syndrome	☐ Yes
stomach ulcer	☐ Yes
stroke	☐ Yes
varicose veins	☐ Yes

Fill in the circles completely for medical history "yes" answers for this page.

Type_____

Name_____Date_____

Social History

Tobacco Use:

Tobacco Use ◯ Yes ◯ No

Drugs/Alcohol:

Alcohol Use ◯ Yes ◯ No

Sexual History:

Sexually active (optional) ◯ Yes ◯ No ◯ Deferred

Family History

Father	☐ Diabetes	☐ Cancer	☐ Foot Deformity	☐ Neuromuscular disease
Mother	☐ Diabetes	☐ Cancer	☐ Foot Deformity	☐ Neuromuscular disease
Siblings	☐ Diabetes	☐ Cancer	☐ Foot Deformity	☐ Neuromuscular disease

Surgical History

Vascular Leg Surgery ☐ Yes

CABG ☐ Yes

Foot/Ankle Surgery ☐ Yes

chemotherapy ☐ Yes

Joint replacement ☐ Yes

Transplant ☐ Yes

General/Constitutional

Chills ◯ Yes ◯ No

Fever ◯ Yes ◯ No

Gastrointestinal

Nausea ◯ Yes ◯ No

Peripheral Vascular

Decreased sensation in extremities ◯ Yes ◯ No