Welcome to Foot Specialists of Mississippi

Amory, Mississippi

First Name: _____M.I: _____ Last Name: _____

Birth Date ____-____- _____ Age: ____ Sex: ____ Race:____ SS#: _____

Mailing Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____Work Phone or Cell Phone: _____ **PHARMACY:** _____

Employer: _____ Employer Phone: _____

Primary Care Physician: _____Phone: _____ Have you ever been a patient in our Practice? Y N

Emergency Contact:_____ Address:_____ Phone: _____

GUARANTOR

Responsible for Account: _____ Relationship: _____

Birth Date ____-____- _____ SS#:_____ Home Phone: _____

Mailing Address: _____ City: _____ State: _____ Zip: _____

Employer: _____ Employer Phone: _____

INSURANCE INFORMATION

Is this visit related to accident/injury? ____ Accident Date: ___/___/____ Is this work related? ____ Have you notified your supervisor: _____

Explain what happened: _____

Primary Health Insurance: _____ Employer: _____ Group#: _____

Subscribers Name: _____ Sub. DOB: _____ SS #: _____

Policy Number: _____ Relationship to patient:_____

Secondary Health Insurance: _____ Employer: _____ Group#: _____

Subscribers Name: _____ Sub. DOB: _____ SS #: _____

Policy Number: _____ Relationship to patient: _____

HEALTH HISTORY

Today's Date: _____/_____/_____

Is your visit due to accident/injury Y N Work Related Accident Y N

Date of Accident/injury _____/_____/_____ Explain Accident _____

Please Explain your
Reason for today's Podiatry Visit: _____

Weight: _____ Height: _____ Shoe Size: _____ Width: _____ **When Problem Started:**_____

Answer all Questions by stating Yes or No

1. **Are you experiencing any of the following:**

Left or Right foot pain	Y N	Ankle Sprains	Y N	Ingrown toenails	Y N
Feet/Leg Cramping	Y N	Corns	Y N	Flat Feet	Y N
Calluses	Y N	Thick Nails	Y N	Pain in Heels	Y N
Knee Pain R/L	Y N	Bunions R/L	Y N	Backaches	Y N
Warts	Y N	Swollen Ankle/foot	Y N	Poor Circulation	Y N

2. Date of Last Physical Exam: _____/_____/_____Physician Last:_____

3. List all Surgeries with Dates: _____ _____

_____ _____ _____

_____ _____ _____

4. DO YOU HAVE OR HAVE YOU EVER BEEN TREATED FOR ANY OF THE FOLLOWING

Anemia	Y N	Asthma	Y N	Arthritis	Y N
Cancer	Y N	Diabetes	Y N	Difficulty in healing	Y N
Depression/anxiety	Y N	Epilepsy/Seizures	Y N	Heart Disease	Y N
Heart Attack	Y N	Hepatitis	Y N	High Cholesterol	Y N
High Blood Pressure	Y N	Immune Dis./HIV	Y N	Injury/Accident	Y N
Kidney Bladder	Y N	Liver Disease	Y N	Lung Disease	Y N
Phlebitis	Y N	Rheumatic Fever	Y N	Shortness Breath	Y N
Sickle Cell Anemia	Y N	Stroke	Y N	Thyroid Disease	Y N
Tuberculosis	Y N	Vascular Disease	Y N		

5. Have you experienced any effects or allergic reaction from any of the following:

Penicillin	Y N	Aspirin	Y N	Cortisone	Y N	Sulfa Drugs/Sulfates	Y N
Novocain	Y N	Lidocaine	Y N	Codeine	Y N	Latex	Y N
Peanuts	Y N						

ANY OTHER MEDICINES, ETC.: _____

6. Are you currently taking any medications? Y N **If so, list all medications your are currently taking.**
THE DOCTOR WILL NOT BE ABLE TO SEE YOU WITH OUT A LIST OF YOUR MEDICINE.....

_____ _____ _____

_____ _____ _____

_____ _____ _____

7. Is there a family History of:

Diabetes	Y N	Circulatory Problems	Y N	High Blood Pressure	Y N
Bleeding Disorders	Y N	Problems with Anesthesia	Y N		

8. Do you have a Social History of:

Tobacco (pkg/day___)	Y N	Coffee (cups/day___)	Y N	Alcohol	Y N
Substance Abuse (describe)	Y N				

9. WOMEN ONLY: Are you pregnant, or is there any chance you might be? Y N

Are you nursing Y N Last Menstrual Cycle: _____

Are you on Oral Contraceptives, it is important that you understand that antibiotics (and other medications) may interfere with the effectiveness of oral contraceptives. Therefore, you will need to use mechanical forms of birth control for one complete cycle of birth control pills, after the course of antibiotics or other medication is completed.

PLEASE CONSULT W/YOUR PHYSICIAN FOR FURTHER GUIDANCE.

10. Review of Systems: (any problems with in the last 2-3 mths)

HEENT ____ Gastrointestinal ____ Genitourinary ____ Neuropsychiatric ____
Cardiovascular____ Locomotor____ Respiratory____

REVIEWED BY: Initials: _____Date: _____

PRIVACY

Our practice is obligated to protect the privacy of your health information. Therefore, we will not release information regarding your appointments, account information, insurance, etc. during telephone conversations, etc., to anyone unless you authorize us to do so by printing the names of those people below: I hereby authorize FSMS to release information to myself and the following person or persons (i.e.: mother, father, husband, etc.) and accept that FSMS, does not have the ability to verify the identity of individuals who call requesting information.

Name/Address/Phone #: _____**DOB:** _____ **Relationship:**_____

Name/Address/Phone #: _____**DOB:** _____ **Relationship:**_____

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I hereby acknowledge that I have been given the opportunity to read a copy of this practice's Notice of Privacy Practice. I have been given the opportunity to ask any questions I may have regarding this Notice.

_____ _____

Signature/Relationship **Date**

FEES & PAYMENTS

Fees are payable at the time services are rendered. Regardless of form of payment, consult fees are due on appointment day. We will be glad to file for reimbursement with your insurance company after your appointment. An estimate of the charge for any procedure or surgery will be required prior to surgery after insurance benefits are checked by our staff. Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. **It is your responsibility to pay any deductible amount, co-insurance or any other balance not paid for by your insurance company upon appointment.** This signature on file is my authorization for the release of information necessary to process my claim. I hereby authorize payment to this doctor named of the benefits otherwise payable to me and certify by signing that I am responsible for the balance of this account. Payments are due and payable at Creditor's place of business as shown on the bills, statements, and at Creditor's home office at 1107 Earl Frye Blvd., Suite 1 & 2, Amory, MS 38821. Debtor agrees to pay interest on all overdue amounts at the rate of 1.5% per month (18% annual percentage rate) or such other lesser amount as is allowed by laws of the state where this debt is incurred. If this account is referred for collection, Debtor agrees to pay Creditor an additional 33 1/3 of the original bill to include interest ($150.00 minimum) as attorney fees, plus all pre-judgment costs of collection,

_____

Signature of person responsible for account

CONSENT FOR TREATMENT

I understand the importance of a truthful Health History to assist the doctor in providing the best care possible, I certify that I have read and understand the questions above. I acknowledge that my questions, If any, about the inquires set forth above have been answered to my satisfaction. I will not hold my Doctor, or any other member of his staff, responsible for any errors or omissions that I have made in the completion of this form.

I authorize the physician, mid-level providers, and clinic to perform or administer such tests, treatments, medications, anesthesia or other medical/surgical treatment as deemed necessary or advisable in the diagnosis or treatment of this patient.

_____	_____	_____
Date	**Signature of Person Completing Health History Consent/patient**	**Relationship**