PATIENT DEMOGRAPHIC FORM

PATIENT INFORMATION

Patient Name: _____ **Social Security #**_____/_____/_____

Date of Birth_____/_____/_____ **Age:**_____ Sex: □ M □ F □ Single □ Married □ Widow/er □ Divorced

Address _____ **Apt**_____ **City**_____ State_____ **Zip code**_____

Home Phone_____ **Cell Phone** _____ **Work Phone** _____

Email Address_____ **How were you referred to our office?**_____

EMERGENCY CONTACT PERSON: _____ **Phone:**_____

Preferred Language:_____ **Race:** _____

GUARANTOR/PARENT INFORMATION (IF NOT SELF)

Responsible Party Name: _____ **DOB**_____/_____/_____ **Social Security No:** _____/_____/_____

Address _____ **Home Phone**_____

Employer_____ **Work Phone**_____

Relationship to Patient_____ **Cell Phone**_____

Highlands Podiatry Patient History Form

PERSONAL INFORMATION:

Patient Name _____ Age _____ DOB_____

Current Weight _____ Height _____ Shoe Size _____

Primary Care Physician _____ Date last seen _____

Referring Physician _____

Have you had a flu shot *this year*? ☐ Yes ☐ No Have you had a pneumonia shot? ☐ Yes ☐ No

PAST MEDICAL HISTORY:

Are you Diabetic? ☐ Yes ☐ No Do you use insulin? ☐ Yes ☐ No Date of Diagnosis _____ Last A1C reading_____

HIV/AIDS? ☐ Yes ☐No Do you/have you had the following? Hepatitis ☐ Yes ☐ No

Please check all that apply:

Amputation ___
Anxiety disorder ___
Arthritis ___
COPD/
Emphysema ___
Depression ___
Diabetes mellitus ___
Gout ___
Heart disease ___
Hypertension ___
CHF ___
Cancer ___

Rheumatoid Arthitis ___
Neuropathy ___
Osteopenia ___
Osteoporosis ___
Peripheral vascular
disease ___
Kidney disease
Liver diease ___
Circulatory problems ___

Other_____

Please describe your current foot: _____

List all medications you take INCLUDING THE DOSAGE AND HOW OFTEN YOU TAKE IT. IF YOU HAVE A LIST, WE CAN MAKE A COPY.

Medication	**Dosage**	**How often?**	**Medication**	**Dosage**	**How often?**

Pharmacy_____

Please list any **allergies**:

_____

_____

_____

Patient History Form Continued

PREVIOUS SURGERIES: (include any complications)

_____ _____

_____ _____

_____ _____

_____ _____

FAMILY HISTORY: Please check ALL that apply

Alcoholism ____
Amputation ____
Arthritis ____
Bleeding disorders ____
Blood clots ____
Bunions/foot deformity ____
Cancer ____
Diabetes ____
mellitus
Heart disease ____

Heart problems ____
Kidney disease ____
Liver problems ____
Neurologic disease ____
Peripheral vascular disease ____
Rheumatoid arthritis ____

Other _____

SOCIAL HISTORY: (circle)

Smoking Status:	Non-smoker	Former Smoker	Current Smoker
Alcohol Use:	Non-drinker	Social Drinker	Daily Use
Illegal Drug Use:	Never Used	Former User	Current User

Occupation _____

REVIEW OF SYSTEMS: Please circle any CURRENT symptoms you are experiencing

Systemic	Fever Chills Weight gain/loss Nausea Vomiting Feeling poorly	None
Cardiovascular	Chest pain Shortness of breath	None
Motor	Difficulty walking Weakness (right left both) Morning stiffness in joints	None
Neurological	Numbness in feet Leg pain Back pain Para theses (nerve sensations)	None
Derm	Rash Masses Skin color changes Itching	None
Vascular	Calf/leg cramps at night Calf/leg cramps while walking Edema (swelling of legs) Cold fingers/toes Cold intolerance	None

*Please note: we may take x-rays during your visit, so please inform us if there is a chance you may be pregnant. Also, medications we may prescribe (i.e. antibiotics) could change the effectiveness of birth control medications.

If you would like a copy of your continued care document from today, please inform the front office.

I understand the completeness and accuracy of this information is critical to receiving safe and effective medical care and I have completed this form to the best of my ability.

➔**Signature:** _____ **Date:**_____

Highlands Podiatry
2765 West State Street
Bristol, TN 37620

Highlands Podiatry
616 Campus Drive, Suite 300
Abingdon, VA 24210

Protected Health Information
HIPAA

I give my consent for Dr. John Allen and Dr. Patrick Saavedra to use and disclose, protected health information about me to carry out treatment, payment and healthcare operations.

I have the right to review the Notice of Privacy Practices prior to signing this consent. (Let the front desk personnel know if you would like to review this information)
Highlands Podiatry reserves the right to revise its Notice of Privacy Practices at anytime.

With this consent, Highlands Podiatry and staff may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out treatment, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory results.

I give my consent for Highlands Podiatry and staff to release medical information to the following person(s):

(1) _____ Relationship_____
(2) _____Relationship_____
(3) _____Relationship_____
(4) _____Relationship_____

I give permission for you to release my medical records to my primary care doctor.
Yes_____ No_____

By signing this form, I am consenting to Highlands Podiatry to the use and disclosure of my ***Protected Health Information*** to carry out treatment.

_____ _____
Signature of patient or legal guardian Date

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Abingdon, VA 24210

Financial Agreement and Consent to Treat

Thank you for choosing Highlands Podiatry to serve your podiatric needs. We are committed to treating you with excellence and respect. If you have any questions regarding your care, please do not hesitate to ask. We have a responsibility to help our patients understand the balances they may be responsible for.

- If you are a Medicare patient and do not have a supplemental plan or a Medicare Advantage Plan, you are responsible for payment of the annual deductible, coinsurance, and non-covered services at the time of service.
- Of you have a high deductible health plan and have not met your annual deductible amount on the date of service, you will be asked to pay 50% of the allowed charged at the time of service. You will be billed for an any additional amounts after the insurance processes the claim.
- Please note that if you are unable to provide your insurance information, we will require that you pay in full for the services you received at the time of the visit. It is urgent that you bring your most recent insurance cards to your appointment.
- All patients are expected to pay any deductibles, coinsurance, or copay amounts owed at the time of service. Our office accepts cash, personal checks, debits cards and all major credit cards. There is a $30 charge for returned checks.
- If your balance is not paid in full within 90 days, your account may be a third party collection agency. If your account is placed with our collections agency, your account may be subject to interest charges and penalties. You also give your consent to receive phone calls on our cell phone regarding any outstanding balances you may have.
- Missed appointments are costly to the physician and the patients in his care. Please help us serve you better by keeping scheduled appointments or by canceling an appointment 24 hours in advance.
- **Consent for Care-**I hereby give my consent for treatment to Highlands Podiatry, PLC. John C. Allen and Patrick M. Saavedra, DPM and staff including treatment or services, and which may include but not limited to laboratory procedures, examination, medical treatment or procedures rendered for me/my dependent under the general and specific instructions of the patients physician.

I acknowledge that payment is due at the time of treatment unless other arrangements are made. I agree that parents, guardians, or personal representatives are responsible for all fees and services performed on a minor/child. I accept full financial responsibility for all charges for services or items provided to me, to my minor/child, or to the patient for whom I have legal responsibility.

I understand that filing a claim with my Insurance Company does not relieve me from my responsibility for the payment for all charges.

_____ _____

Signature of Patient, Parent or Guardian ***Date***