NORFOLK FOOT AND ANKLE GROUP PC
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* **JOHN P. D'AMELIO, D.P.M.**

* *Diplomate American Board of Foot and Ankle Surgery*
* *Fellow American College of Foot and Ankle Surgeons*
** *Diplomate American Board of Orthopaedics & Primary Podiatric Medicine*
** *Fellow American College of Foot & Ankle Orthopaedics & Medicine*

Norfolk Foot and Ankle Group, P.C.'s Electronic Health Record, Practice Fusion, has the capability for our patients to access their Personal Health Information (PHI) online. To access your PHI, you must provide our office with your personal email address or the email address of your personal representative. If you decline to provide our office with your email address, you will not be able to view, download, or transmit your PHI. Once we enter your email address into your personal portal you will receive login information from Practice Fusion via email with instructions on how to create your online account. Norfolk Foot and Ankle Group, P.C. cannot provide you with a unique PIN, register username and password. This can only be issued by Practice Fusion after providing our office your personal email address or the email address of your personal representative. Once you create your account you will receive your unique login information from Practice Fusion and will be able to login and view you PHI. You will be able to login using your unique PIN, issued to you by Practice Fusion or your email, address, phone number, and date of birth. Practice Fusion has a Help forum that you can utilize if you need assistance creating your account. The web address is: helpforum@patientforum.com. Practice Fusion's web address is www.practicefusion.com. A clinical summary is available upon request. If not, we trust that you decline to receive a clinical summary.

( ) I would like to access my PHI and I am providing you with my email address:

_____

( ) I decline to provide you with my email address and therefore will not access my PHI.

Norfolk Foot and Ankle Group, P.C. has provided me with necessary information needed to view, download or transmit my PHI from Practice Fusion.

Sign: _____

Print: _____

Date: _____

3720 Holland Road, Suite 100
Virginia Beach, Virginia 23452
(757) 498-0202
Fax (757) 498-7936

3509 Granby Street, Suite B
Norfolk, Virginia 23504
(757) 451-1220
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Dr. John P. D'Amelio
Dr. Robert D. Tupper
Dr. N. Wynta Williams
Dr. C. Christopher Nicholas
Dr. Lauren Shouldis

~Podiatric Medicine and Foot Surgery
~Reconstructive Foot Surgery
~Diabetic Foot Care and Surgery
~Foot and Ankle Trauma
~Foot and Ankle Sports Medicine

PLEASE PRINT

Today's Date:_____

Patient Registration Form

Welcome to our practice. Please feel free to ask us if you need help answering any of the following questions. We will be happy to assist you.

Personal History:

Patient Name:_____Sex (circle one): M F
Address:_____City/State/Zip:_____
Home Phone:_____Work Phone:_____Cell Phone:_____
What is your... Height_____ Weight_____ Shoe Size_____ Shoe Width_____
SS#:_____Birth Date:_____Age:_____Marital Status(circle one): S M W D
Employed By:_____Occupation:_____
Address:_____City/State/Zip:_____
Primary Insurance:_____Policy Holder Name:_____
Secondary Insurance:_____Policy Holder Name:_____
Emergency Contact Name:_____Phone:_____
Primary Doctor:_____Phone:_____
Date of Last Visit with Primary Doctor:_____Referred by:_____

Patient's Guardian or Power of Attorney:

Name:_____ Birth Date:_____SS#:_____
Relationship to Patient:_____Home Phone:_____Cell Phone:_____
Address:_____City/State/Zip:_____
Employed By:_____Occupation:_____Work Phone:_____

History of Present Illness:

What brought you in to see the Doctor?_____
Where is the exact location of your problem?_____
How long has the problem been present?/What is the date of your first symptom?_____
Have you had prior treatment for this problem?_____If yes...What?_____
Is this problem work related?_____If yes...What is the workman's comp. #?_____
Is this problem due to an injury?_____If yes...What is the exact date of injury?_____

Pharmacy Information:

Pharmacy Name:_____
Pharmacy Phone Number/Address:_____

Patient Medical History:

Have you ever had any of the following:

_____AIDS	_____Circulatory Problems	_____Jaundice	_____Sciatica
_____Anemia	_____Diabetes	_____Kidney Disease	_____Shortness of Breath
_____Alzheimer's	_____Epilepsy	_____Liver Disease	_____Stomach Ulcer
_____Arthritis	_____Glaucoma	_____Lung Disease	_____Stroke
_____Asthma	_____Gout	_____Nerve Disorder	_____Thick Scar/Keloid
_____Back Problems	_____Headaches	_____Osteoporosis	_____Thyroid Problems
_____Bleeding Disorder	_____Heart Conditions	_____Phlebitis	_____Tuberculosis
_____Blood Transfusion	_____Hemophilia	_____Psychiatric Care	_____Tumors
_____Cancer	_____Hepatitis	_____Radiation/Chemo	_____Ulcers/Lesions(Foot/Leg)
_____Chest Pain	_____High Blood Pressure	_____Rheumatic Fever	_____Varicose Veins
	_____High Cholesterol		

How is your general health? (circle one): Good Fair Poor Are you currently pregnant?_____

Have you been under a physician's care during the last 2 years?_____If yes...Please explain:_____

Surgery History:

Have you ever been hospitalized or been under medical care for over 24 hours?_____If yes...Please explain:

Have you ever had surgery?_____If yes...Please explain:

Surgery was for	date	complications

Social History:

Do you smoke now?_____Packs/day_____# of years_____ If you quit...When?_____Packs/day_____# of years_____
Alcoholic Beverages (circle one): None Social Daily Quit
Recreational Drugs (circle one): None Social Daily Quit

Family History:

List which immediate family member has had the following:
Diabetes_____ Foot Problems_____ Arthritis_____
Heart Attack_____ High Blood Pressure_____ Stroke_____
Cancer_____ Birth Defects_____ Other_____

Medications

Are you currently taking any medications?_____If yes...Please list them below:

Medication Name	Dosage	Medication is for

Allergies:

Are you allergic to any of the following? If yes...Please explain:

_____Adhesive Tape_____
_____Antibiotics_____
_____Aspirin_____
_____Codeine_____
_____Cortisone_____
_____Demerol_____
_____Empirin_____
_____Foods_____
_____Iodine_____
_____Latex_____
_____Morphine_____
_____Motrin_____
_____Narcotics_____
_____Neosporin_____
_____Novocain_____
_____Penicillin_____
_____Sulfa Drugs_____
_____Other_____

Review Of Symptoms

***Please indicate if you are having any current problems:

General
____Chronic fatigue
____Weight loss(amount____since when____)
____Fever
____Anemia
____Bruise easily/Bruise too long
____Depression
____Nervousness/panic attacks

Ears, Eyes, Nose & Throat
____Ringing in ears
____Ear infections
____Dizzy spells
____Poor vision
____Glaucoma
____Sinus trouble
____Hoarseness
____Eye infections

Gastrointestinal
____Diarrhea
____Gas/Bloating
____Heartburn
____Regurgitation
____Difficulty swallowing
____Painful swallowing
____Nausea
____Vomiting
____Constipation
____Abdominal pain
____Decreased appetite
____Blood in stools
____Black stools
____Jaundice/Dark urine

Lungs
____Pneumonia
____Asthma
____Cough
____Shortness of breath
____Hemoptysis

Heart
____Chest pain
____Irregular heart beat
____Ankle swelling
____High blood pressure

Skin
____Rashes
____Hives
____Allergic reaction

Urinary
____Urine infections
____Kidney stones
____decreased urine force/flow
____urination at night
____blood in urine
____painful urination

Bones & Joints
____Arthritis/rheumatism
____Back pain
____Gout
____Osteoporosis

Neurological
____Stroke
____Seizures
____Headaches
____Numbness/Tingling

Any additional heath concerns:_____

I certify that the above information is correct. I understand that I am responsible for payment of services as they are rendered. If this account is referred to an attorney for collection then the undersigned person(s) promise and agree to pay all collection costs including attorney fees of 33 1/3% of the principal amount due and owing when turned over for collection and do further agree to pay interest at a rate of 1 1/2% per month (18% per Annum) on the unpaid balance from the date the services were last rendered. I authorize photocopies of this form to be as valid as the original. In the event this matter is turned over for collection, I hereby expressly give permission for my current employer(s) to provide verification of my said employment to this office, or their attorney Tiffany & Tiffany, P.L.L.C.

Date:_____ Patient/Resp. Party Signature:_____

Medicare Patient's Lifetime Authorization

I request that payment of authorized Medicare benefits be made to the doctors for any services rendered to patient by the physician. I authorize any holder of Medicare to release information about me to the healthcare financing administration and insurance agents. I also authorize any holder of Medicare to release information needed to determine the benefits or the benefits payable for related services.

Date:_____ Patient/Resp. Party Signature:_____

Broken Appointment/Cancellation Policy

We are pleased you have made an appointment with our office. In order to serve our patients better, we have instituted a cancellation policy. A missed appointment results in lost time which could be used for another patient waiting to receive treatment, therefore it is important that you keep you appointments. Valuable time has been reserved just for you.
If you are unable to keep your appointment, we require you to contact us 24 hours in advance when canceling. If you do not cancel 24 hours in advance you will be charged a cancellation/no show fee of $25. If you fail to show for a scheduled appointment, all future appointments you may have scheduled will be canceled. If you wish to continue your treatment in our office, you must schedule a new appointment. We look forward to seeing you at the time that has been reserved especially for you!

Thank you, Norfolk Foot and Ankle Group

Date:_____ Patient/Resp. Party Signature:_____

Patient HIPAA consent form

Use of this form is optional and not required under the HIPAA privacy rule.

Norfolk Foot and Ankle Group, PC

Patient Consent for Use and Disclosure of Protected Health Information

I hereby give my consent for Norfolk Foot and Ankle Group, PC to use and disclose protected health information (PHI) about me to carry out treatment,payment and health care operations (TPO). (The Notice of Privacy Practices provided by Norfolk Foot and Ankle Group, PC describes such uses and discloses more completely.)

I have the right to review the Notice of Privacy Practices prior to signing this consent. Norfolk Foot and Ankle Group, PC reserves the right to revise it Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by fowarding a written request to Norfolk Foot and Ankle Group, PC 3720 Holland Road, Suite 100, Virginia Beach, VA 23452.

With this consent, Norfolk Foot and Ankle Group, PC 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 TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory test results, among others.

With this consent, Norfolk Foot and Ankle Group, PC may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked "Personal and Confidential."

With this consent, Norfolk Foot and Ankle Group, PC may e-mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that Norfolk Foot and Ankle Group, PC restrict how it uses or discloses my PHI to carry out TPO. The practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to allow Norfolk Foot and Ankle Group, PC to use and disclose my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Norfolk Foot and Ankle Group, PC may decline to provide treatment to me.

_____ _____

Signature of Patient or Legal Guardian Date

_____

Print Name of Patient or Legal Guardian