Please Print

Personal History

First Name: _____ Middle: _____ Last Name: _____

Address: _____ City/State/Zip: _____

Home #: _____ Work #: _____ Cell #: _____

Birth Date: _____ Age: _____ (Circle) Sex: M F Marital Status: S M W D

SS#: _____ Height: _____ Weight: _____ Shoe Size: _____ Shoe Width: _____

Employer: _____ Address: _____

City/State/Zip: _____ Occupation. _____

Emergency Contact Name: _____ Phone#: _____

Primary Doctor: _____ Phone#: _____ Date of Last Visit: _____

Patient Guardian/Power of Attorney

Name: _____ Birth Date: _____ SS#: _____

Relationship to Patient: _____ Home#: _____ Cell#: _____

Address: _____ City/State/Zip: _____

History of Present Illness

What brought you in to see the Doctor: _____

Location of your problem. _____ 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 Comp. #: _____

Is this problem due to an injury: _____ If yes, What is the exact date of injury: _____

Pharmacy Information

Pharmacy: (Circle) Walgreens/Rite Aid/CVS/Harris Teeter/Kroger/Walmart/Other: _____

Pharmacy Address: _____ Phone#: _____

Current Medication Listing

Medication Name	Dosage	Reason for Medication

Patient Medical History (Have you ever had any of the following Please Check)

__ 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	__ Phiobitis	__ Tuberculosis
__ Blood Transfusion	__ Hemophilia	__ Psychiatric Care	__ Tumors
__ Cancer	__ Hepatitis	__ Radiation/Chemo	__ Ulcers/Lesions (Foot/Leg)
__ Chest Pain	__ High Blood Pressure	__ Rheumatic Fever	

How is your general health (Circle) Good/Fair/Poor Are you currently pregnant: Yes or No

Have you been under a physician's care during the last 2 years: Yes or No If Yes, Please Explain:

_____

_____

Surgery History

Have you ever been hospitalized or been under medical care for over 24 hours: Yes/No If Yes, Please Explain:

_____

Have you ever had surgery: Yes or No If Yes, Please list the following

Surgery Reason	Surgery Date	Complications
_____	_____	_____
_____	_____	_____
_____	_____	_____

Social History

Current Smoker: Y/N Packs Per Day: _____ # of Years _____ If you quit, When (Month/Year) _____

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: _____

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)

Gastrointestinal

___ Blood in Stools
___ Black Stools
___ Diarrhea
__ Gas/Bloating
___ Heartburn
___ Regurgitation
___ Difficulty Swallowing
___ Painful Swallowing
___ Nausea
___ Vomiting
___ Constipation
___ Abdominal Pain
___ Decreased Appetite
___ Jaundice/Dark Urine

Bones & Joints

___ Arthritis/Rheumatism
___ Back Pain
___ Gout
___ Osteoporosis

Neurological

___ Stroke
___ Seizures
___ Headaches
___ Numbness/Tingling

Heart

___ Chest Pain
___ Irregular Heart Beat
___ Ankle Swelling
___ High Blood Pressure

Ears/Eyes/Nose/Throat

___ Ringing in Ears
___ Ear Infections
___ Dizzy Spells
___ Poor Vision
___ Glaucoma
___ Sinus Trouble
___ Hoarseness
___ Eye Infections

Neurological

___ Stroke
___ Seizures
___ Headaches
___ Numbness/Tingling

Urinary

___ Urine Infections
___ Kidney Stones
___ Urination at Night
___ Blood in Urine
___ Painful Urination
___ Decreased Urine Force/Flow

Skin

___ Rashes
___ Hives
___ Allergic Reaction

General

___ Chronic Fatigue
___ Weight Loss
(Amt. ____/Month & Year _____)
___ Fever
___ Anemia
___ Bruise Easily/Too Long
___ Depression
___ Nervousness/Panic Attacks

Any additional health 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 fee and owing when turned over for collection and do further agree to pay interest at a rate of 1 ½% 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 giver 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.

Initials: _____

Medicare Patients 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.

Initials: _____

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 your appointments. Valuable time has been reserved just for you. If you are unable to keep your appointment, we require you 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 on behalf of Norfolk Foot and Ankle Group.

Initials: _____

Patient HIPAA Consent Form

Use of this form is optional and not required under the HIPAA privacy rule. 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 treatments, 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. By initialing, I am consenting to allow Norfolk Foot and Ankle Group, PC to use and disclose my PHI to carry out TPO. (Patient is provided a copy).

Initials: _____

Policy for Forms Completion

We will be happy to complete any Disability, Aflac or FMLA forms you require. Please allow at least 7 to 10 days for completion of these forms. The following prepaid charges will apply:

First Form: One Page - $20 Multi Pages: $35

Subsequent Forms (Monthly or Recurring): One Page - $10 Multi Pages - $15

Surgical Cancellation Policy

The scheduling of your surgery is time consuming and very complex. When rescheduling has to occur, the scheduling process has to be repeated again in total. This includes significant time spent coordinating with the hospital, primary care physician and insurance company. If you request that any surgical procedure be rescheduled or canceled for any reason with 5 business days of the scheduled procedure, there will be a $100 cancellation/rescheduling fee.

Follow Up Test Results Policy

If your physician has requested that you have a testing done, it is your responsibility to make sure you have scheduled a follow up visit to discuss all findings within 2 to 3 weeks after the testing has been completed. This is to ensure that we provide the best medical health care possible for all patients.

Personal Health Information (PHI) Practice Fusion Electronic Health Record Online

Norfolk Foot and Ankle Group. P.C. has the capability for our patients to access their personal health information 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 out 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. Once you create your account, you will receive your unique login information from Practice Fusion and will be able to login and view your PHI. You will be able to login using your unique pin, your email address, phone number or 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 web address is www.practicefusion com. A clinical summary is available upon request. If not, we trust that you have decline to receive a clinical summary.

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

Email Address: _____

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

Sign Name: _____

Print Name: _____

Date: _____