MARLBORO PODIATRY CENTER

Patient's Name: _____ Date of Birth: _____ Chart # _____ Date: _____

MEDICAL HISTORY: Please Circle if any of the following apply to you:

AIDS/HIV
Allergy to Anesthetic
Anemia
Angina
Arthritis; Osteo; Rheumatoid
Artificial Heart/Valve/Joint
Asthma
Back Problems
Bladder Problems
Bleeding Disorders
Cancer, Type: _____
Chemical Dependency
Chest Pain/Palpitations
Cholesterol: High or Low
Chronic Diarrhea
Circulatory Problems
Diabetes, Type: _____
Ear Problems
Epilepsy/Seizures
Heart Murmur
Tingling or Numbness
Itching or Athlete's Foot
Cataracts
Abdominal Pain
Eye Problem
Fainting
Frequent Infections
Gout
Headaches
Hearing Problems
Heart Disease:
Hemophilia
Hepatitis or Jaundice
High Blood Pressure
Immune Disorders
Kidney Disease/Kidney Stones
Liver Disease
Low Blood Pressure
Neurological
Neuropathy
Phlebitis
Psychiatric Care
Radiation Treatment
Heart Attack
Tremors
Slow Healing Wound
Glaucoma
Heartburn
Rash
Respiratory Disease
Rheumatic Fever
Shortness of Breath
Sinus Problems
Skin Cancer
Special Diet
Stroke
Swelling in Ankles, Feet
Swollen Neck/Glands
Thyroid
Tired Feet
Tuberculosis
Ulcers - Stomach, Other:_____
Varicose Veins
Venereal Disease
Weight Loss, unexplained
COPD
Nail Abnormalities
Mitral Valve Prolapse (MVP)
Vascular Disease
Constipation
Diarrhea
Blood in Stool

Other: _____

_____

SURGICAL HISTORY: Please provide dates if able

_____

_____

_____

FAMILY HISTORY: Please provide any medical conditions family members have/had:

MOTHER: _____
FATHER: _____
BROTHER: _____
SISTER: _____
OTHER FAMILY: _____

SMOKING: NEVER FORMER CURRENT IF CURRENT HOW MANY PACKS PER DAY?_____

ALCOHOL: NEVER RARE SOCIAL 3-4 TIMES PER WEEK EVERYDAY (5-7 times per week)

Please Read and Sign: The above information is correct to the best of my knowledge. I understand that throughout my treatment I am responsible for notifying the physician and/or medical staff of any and all updates to the information related to my health. I authorize payments directly to the physician for surgical and/or medical benefits. In addition, I understand I am responsible for any portion of my bill not covered by my insurance.

_____ _____ _____

Signature of patient or representative Print Name Date

Practice: MARLBORO PODIATRY CENTER **Today's Date:**

Name: _____ **Chart #:** _____ **Date of birth:** _____

Ethnicity: ☐Hispanic or Latino ☐Not Hispanic or Latino ☐Declined to specify

Race: ☐Asian ☐American Indian or Alaska Native ☐Black or African American

☐White ☐Native Hawaiian or other Pacific Islander ☐Declined to specify

Preferred Language: English ☐Declined to specify

Pharmacy Name: _____ **Pharmacy Phone:** _____

Pharmacy Address: _____ City, State, Zip: _____

Primary Care Physician: _____ Phone: _____ Date Last Seen: _____

Address: _____

Referring Physician: _____ Phone: _____ Date Last Seen: _____

Address: _____

Privacy Information Preferences

Do you want to be exempt from public reporting? ☐Yes ☐No Can we send mail to the address on file? ☐Yes ☐No

Can we call the phone number on file? ☐Yes ☐No Can we leave voicemail on machine? ☐Yes ☐No

Will you allow us to send internet based (e-mail) delivery of reminders and newsletters? ☐Yes ☐No

If yes, please provide your e-mail address: _____

Who can we leave messages with? ☐Wife ☐Husband ☐Daughter ☐Son ☐Other: _____

Name(s): _____

Smoking Status

☐Current Every Day ☐Smoker, Current Status Unknown

☐Current Some Day ☐Heavy Tobacco ☐Unknown If Ever

☐Former ☐Never ☐Light Tobacco ☐I decline to answer

Vital Signs

Blood Pressure: _____ / _____

Height: _____ Weight: _____

Current Medications

☐ No Known Medications ☐ I take the following medications:

Name: _____ Dose: _____

Name: _____ Dose: _____

Name: _____ Dose: _____

Name: _____ Dose: _____

Name: _____ Dose: _____

Name: _____ Dose: _____

Name: _____ Dose: _____

Name: _____ Dose: _____

Name: _____ Dose: _____

Use the back of this form if more room is needed

Allergies

☐ No Known Allergies ☐ No Known Drug Allergies

Name: _____ Reaction: _____

Name: _____ Reaction: _____

Name: _____ Reaction: _____

Name: _____ Reaction: _____

Name: _____ Reaction: _____

Name: _____ Reaction: _____

Name: _____ Reaction: _____

Name: _____ Reaction: _____

Name: _____ Reaction: _____

Did you get a pneumococcal vaccination? ☐Yes ☐No

PLEASE READ AND SIGN: The information on my intake form(s) is correct to the best of my knowledge. I understand that throughout my treatment, I am responsible for notifying the physician and/or medical staff of any and all updates to the information listed above. *(Assignment of Benefits)*: I authorize payment of medical benefits to the practice named above. *(Release of Information)*: I authorize the release of any medical information necessary to process this claim. *(HIPAA Privacy)*: I acknowledge that I received my HIPAA Privacy Practices Notice. *(Medication History)*: I authorize the Doctor's office to retrieve my medication history.

Patient Signature: _____ Date: _____

Rev 2/6/2014

MARLBORO PODIATRY CENTER

HIPAA
Acknowledgements and Authorizations

I. HIPAA Notice of Privacy Practices

Patient Acknowledgement

We are required by law to maintain the privacy of protected health information, and provide individuals with this Notice of our legal duties and privacy practices with respect to protected health information. If you have any questions, please speak with our HIPAA Compliance Officer in person or by phone at our main phone number.

Signature below is only acknowledgement that you have been given the option of receiving a copy or been afforded an opportunity to review our Notice of our Privacy Practices:

Print Name:_____ Date of Birth: _____

Signature:_____ Date: _____

II. Authorization for use or Disclosure of Health Information

Patient Contact Information

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

I authorize Brief messages with medical information to be left on voicemail at (check all that apply): ☐ Home ☐ Cell ☐ Work

I authorize Extended messages with medical information to be left on voicemail at (check all that apply): ☐ Home ☐ Cell ☐ Work

I authorize secure electronic communications be sent to my email address at: _____

Restrictions/Instructions: _____

Release of Medical History and Treatment Information

I authorize the following individual(s) to receive information pertaining to any medical history and treatment received:

Name:_____ Relationship:_____ DOB:_____ Ph #: _____

Name:_____ Relationship:_____ DOB:_____ Ph #: _____

Restrictions: _____

Release of Billing Information

I authorize the following individual(s) to receive information pertaining to any billing issue and to act on my behalf:

Name:_____ Relationship:_____ DOB:_____ Ph #: _____

Name:_____ Relationship:_____ DOB:_____ Ph #: _____

Restrictions: _____

Patient Acknowledgement

In accordance with the Privacy Rule of the Health Insurance Portability and Accountability Act (HIPAA) of 1996, I understand that:

1. I may revoke this authorization at any time, except to the extent where action has already been taken in accordance to the original authorization for disclosure. My revocation must be in writing, signed by me or on my behalf, and delivered to our office address. My revocation will be effective once received by the practice, Marlboro Podiatry Center.
2. A copy of this authorization may be used with the same effectiveness as the original.

This authorization replaces any prior written authorization I have made regarding the use, release, and disclosure of my medical information.

Print Name:_____ Date:_____

Signature:_____ Relationship: _____

Additional Authorizations

Emergency Contact:_____ Relationship:_____ Phone:_____

CONTINUED ON REVERSE SIDE

Patient's Name: **DOB:**

Authorization for Treatment & Payment of Medical Benefits
Patient Financial Responsibility Form

Thank you for choosing our practice, Marlboro Podiatry Center, as your healthcare provider. We appreciate the confidence you have shown by your choice and are committed to providing you with the highest quality healthcare. We ask that you read and sign this form to acknowledge your understanding of our authorization for treatment, payment, and patient financial policies. If you would like to receive a more detailed explanation of our financial policies, please request a copy.

Authorization for Treatment & Payment of Medical Benefits

I give permission to the practice, Marlboro Podiatry Center, to provide medical services for diagnosis and treatment. I authorize the release of medical information necessary to process any claims for services rendered and for payment from my insurance company to be made directly to the practice, Marlboro Podiatry Center.

Use of Photography

I agree that any photo identification taken at the time of my appointment will be considered a part of my medical record and will be used solely for the purpose of identification.

e-Prescription Consent for Medication History

With your consent, we may request and use your prescription medication history information using our e-prescription feature. This is for only informational purposes so that an up-to-date record of your medication is available for your treatment and safety.

☐ Yes, I give consent to obtain my medication history using the e-Prescribing feature.

☐ No, I do not give consent to obtain my medication history using the e-Prescribing feature. I understand that my medication information may not be complete when making treatment decisions.

Patient Financial Responsibilities

- I (or patient's guardian, if a minor) understand that I am ultimately responsible for the payment of my treatment and care.
- You will assist me by billing your contracted insurers. However, I understand that I am required to provide you with the most correct and updated information about my insurance, and I will be responsible for any charges incurred if the information provided is not correct or updated.
- I understand that I am responsible for the payment of copays, coinsurance, deductibles, and all other procedures or treatment not covered by my insurance plan. I understand that payment is due at the time of service, payable by cash, check, and most major credit cards (**Visa, Mastercard, or Discover**).
- I understand that I may incur, and am responsible for, the payment of additional charges. These charges may include (but are not limited to):
    - Charge for returned checks.
    - Charge for the copying and distribution of patient medical records.
    - Charge for forms completion.
    - Charge for missed appointments.

Patient Authorizations

- By my signature below, I hereby authorize the practice, Marlboro Podiatry Center, to release medical and other information to the necessary insurance companies and third party payers required for payment of rendered health services.
- By my signature below, I hereby authorize assignment of financial benefits directly to the practice, Marlboro Podiatry Center. I understand that I am financially responsible for charges not covered or denied in full or in part by my insurance plan(s).

I have read, understand, and agree to the provisions of this Authorization for Treatment & Payment of Medical Benefits and Patient Financial Responsibility Form:

Signature of Patient or Guardian **Date**

CONTINUED ON REVERSE SIDE