Samuel T. Wood, DPM. LLC

PATIENT REGISTRATION FORM

All information provided on this form will remain confidential in compliance with HIPAA guidelines

Please Print

PATIENT INFORMATION

Name _____ Male ☐ Female ☐

Social Security Number _____ Birth Date _____

Address _____
Street *City* *State* *Zip Code*

Home Phone _____ Cell Phone _____ Other _____

Are You Employed? Yes ☐ No ☐ Full Time ☐ Part Time ☐

Employer _____

Address _____
Street *City* *State* *Zip Code*

Primary Care Doctor _____

Address _____
Street *City* *State* *Zip Code*

In the case of an emergency, whom should we contact? _____

Relationship _____ Home Phone _____ Work Phone _____

RESPONSIBLE PARTY

The person who supplies the patient's insurance or who is responsible for payment if uninsured.

Name _____ Social Security Number _____

Male ☐ Female ☐ Birth Date _____ Relationship to the Patient _____

Address _____
Street *City* *State* *Zip Code*

Home Phone _____ Cell Phone _____ Other _____

Is the Responsible Party currently a patient with our practice? Yes ☐ No ☐

INSURANCE INFORMATION *Please give **all** cards to the receptionist so we may copy them.*

Primary Insurance Company Name _____

Secondary Insurance Company Name _____

REFERRAL INFOMRATION

How did you learn about our practice?

☐ Primary Care Doctor _____ _____
Name *Address* *City/State* *Zip Code*

☐ Other Doctor _____ _____
Name *Address* *City/State* *Zip Code*

☐ Friend/Relative _____ _____
Name *Address* *City/State* *Zip Code*

☐ SWB Phone Book ☐ Other Phone Book ☐ Insurance Company ☐ Newspaper

☐ Television ☐ Radio ☐ Direct Mail ☐ Internet

ASSIGNMENT and RELEASE

I certify that I have insurance coverage as indicated above. I hereby assign directly to Samuel T. Wood DPM., LLC all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not payment is made by insurance including, but not limited to, the deductible, copayment, coinsurance, and any noncovered services. I understand that if my account is not paid when due, I will be responsible for all costs incurred during the collections process, including collection fees that are assessed. Coinsurance and deductible are based upon the amount of payment determined by my insurance carrier. I authorize Samuel T. Wood DPM., LLC. to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

_____ _____

Signature of Responsible Party / Authorized Representative Date

MEDICARE AUTHORIZATION

I request that payment of authorized Medicare benefits be made on my behalf to Samuel T. Wood DPM., LLC, for any services furnished me by their physician. I authorize any holder of medical information about me to release to the Centers for Medicare & Medicaid Services and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requires that payment be made and authorizes release of medical information necessary to pay the claim. If I have health insurance in addition to medicare, my signature authorizes release of the information to the insurer or agency. In Medicare assigned cases, the physician, or supplier agrees to accept the charge determination of the Medicare carrier as the full charge. The patient is responsible only for the deductible, coinsurance, and non-covered services. Coinsurance and deductible are based upon the charge determination of the Medicare carrier.

_____ _____

Signature of Medicare Beneficiary / Authorized Representative Date

3701 N. St. Peters Pkwy, Suite C-1
St. Peters, MO 63376
636-720-0190

Samuel T. Wood D.P.M.

662 Rue St. Ferdinand
Florissant, MO 63031
314-921-1020

1 PATIENT INFORMATION			DATE: / /		
First Name:	M.I.	Last Name:	Shoe Size:	Weight:	Height:
2 COMPREHENSIVE PATIENT MEDICAL HISTORY			PHARMACY PHONE:		

Have you ever had or been treated for:

- ☐ Corns / Callouses
- ☐ Arch Pain
- ☐ Leg or Foot Ulcers
- ☐ Knee Pain
- ☐ Broken Foot Bone(s)
- ☐ In-toeing
- ☐ Cramps in Legs / Feet
- ☐ Rash
- ☐ Lower Back Pain
- ☐ Athlete's Feet
- ☐ Gait (Walking) Problems
- ☐ Ingrown Nails
- ☐ Childhood Foot Problems
- ☐ Foot Numbness
- ☐ Warts
- ☐ Ankle Sprain
- ☐ Fungal Nails
- ☐ Flat Feet
- ☐ Neuroma
- ☐ High Arch Feet
- ☐ Broken Ankle
- ☐ Heel Pain
- ☐ Bunions
- ☐ Toe Walking

Do you have or have you ever been treated for:

- ☐ Stroke
- ☐ Diabetes
- ☐ Gout
- ☐ Alzheimer's
- ☐ Glaucoma
- ☐ Cancer
- ☐ Vascular Disease
- ☐ Liver Disease
- ☐ Rheumatic Fever
- ☐ Nerve Disorder
- ☐ Lung Disease
- ☐ High Blood Pressure
- ☐ Headaches
- ☐ Osteoporosis
- ☐ Hearing / Ear Disorder
- ☐ Thyroid Problem
- ☐ Phlebitis
- ☐ Hepatitis
- ☐ Sciatica or Back Problems
- ☐ Epilepsy
- ☐ Asthma
- ☐ Heart Attack
- ☐ Parkinson's Disease
- ☐ Poor Circulation
- ☐ Arthritis
- ☐ Keloid / Thick Scar
- ☐ Kidney Disease
- ☐ Stomach Ulcer
- ☐ A Heart Condition
- ☐ Anemia
- ☐ Lyme's Disease
- ☐ Psychiatric Disorder
- ☐ Tuberculosis
- ☐ Other: _____

Do you have or have you ever been treated for:

Yes	No	
☐	☐	Are you currently pregnant?
☐	☐	Are you slow to heal after being cut?
☐	☐	Any abnormal bruising, bleeding, or scarring?
☐	☐	Do you smoke?
		# of packs per day _____ Years _____
☐	☐	Did you ever smoke?
		# of packs per day _____ Years _____
		When did you quit smoking? ____/____/____
☐	☐	Does foot pain limit your desired activities?
☐	☐	Do you have any difficulty walking?

Yes	No	
☐	☐	Any pain in calves or buttocks while walking?
☐	☐	Do you get leg cramps during the day?
☐	☐	Do you get leg cramps during the night?
☐	☐	Do you have any vascular grafts?
☐	☐	Do you have any joint implants?
☐	☐	Do you have replacement heart valves?
☐	☐	Are you now under active chemotherapy?

Describe the condition that brings you to our office today.

_____

_____

OVER

Surgeries

Yes No

☐ ☐ Have you had any surgery? (if yes please explain)

☐ ☐ Have you ever been hospitalized or been under medical care for over 24 hours? (if yes please explain)

Had surgery for: Date of surgery:

List any hospitalizations other than for surgery listed above _____

Medications

Name:	Dosage:	Frequency

Allergies:

Yes No

☐ ☐ Latex _____

☐ ☐ Adhesive Tape _____

☐ ☐ Penicillin _____

☐ ☐ Other Antibiotics _____

☐ ☐ Morphine _____

☐ ☐ Codeine _____

☐ ☐ Demerol _____

☐ ☐ Other Narcotics (list below) _____

☐ ☐ Novacaine _____

☐ ☐ Other Anesthetics (list below) _____

☐ ☐ Aspirin or Tylenol (circle) _____

☐ ☐ Other Pain Medication (list below) _____

☐ ☐ Sulfa Drugs _____

☐ ☐ Shrimp, Iodine, or Merthiolate _____

Any other drugs/meds (list below)

_____

_____

_____

I certify that the above information is true and correct to the best of my knowledge. I give the doctor my permission to administer and perform such procedures as may be deemed necessary in the diagnosis and / or treatment of my podiatric condition(s).

_____ _____

Signature of Patient Or Authorized Representative Date

NEW PATIENT Consent Form

New Patient Consent to the Use and Disclosure of Health Information for Treatment, Payment or Healthcare Operations

I, _____, understand that as part of my health care, Samuel T. Wood DPM, LLC originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatments and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment
- A means of communication among the many health professionals who contribute to my care,
- A source of information for applying my diagnosis and surgical information to my bill
- A means by which a third-party payer can verify the services billed were actually provided and
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.

I understand and have been provided with a Notice of Information Practices that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent,
- The right to object to the use of health information for directory purposes, and
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or health care operations.

I understand that Samuel T. Wood, DPM, LLC is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon. I also understand that be refusing to sign this consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

I further understand that Samuel T. Wood, DPM, reserves the right to change their notice and practices and prior to implementation, in accordance with Section 164.520 of the Code of Federal Regulations. Should Samuel T. Wood, DPM, LLC change their notice, they will send a copy of any revised notice to the address I've provided (whether US mail or, if I agree, email).

I wish to have the following restrictions to the use of disclosure of my health information:

_____

_____

I understand that as part of this organization's treatment, payment, or health are operations, it may become necessary to disclose my protected health information to another entity and I consent to such disclosure for these permitted uses, including disclosures via fax.

I fully understand and accept/decline the terms of this consent.

_____

Patient Signature

_____

Date

FOR OFFICE USE ONLY

[ ] Consent received by _____ on _____.

[ ] Consent refused by patient and treatment refused as permitted.

[ ] Consent added to the patient's medical record on_____ .

SAMUEL T WOOD, DPM LLC
ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES
EFFECTIVE DATE: JANUARY 1, 2014

Name of Patient: _____

Do you authorize us to release any information to any other person or persons(spouse, parent, friend, child)? No information, such as test results or appointment changes, can be given to any other person unless listed. List name and relation:

	Name	Relation to patient
1.	_____	_____
2.	_____	_____
3.	_____	_____

May we leave a detailed message regarding test results or other information on your voice mail? Yes No

If your disability insurance carrier requests information about you, either verbally or in writing may we provide requested information? Yes No

I hereby acknowledge that I have received the Samuel T Wood, DPM LLC Notice of Privacy Practices

_____ _____

Signature of Patient or Personal Representative Date

If Personal Representative's Signature appears above, please describe relationship to the Patient:

(FOR COMPLETION BY SAMUEL T WOOD, DPM LLC)
DOCUMENTATION OF GOOD FAITH EFFORTS TO OBTAIN ACKNOWLEDGEMENT

Patient Name:_____ **Date:**_____

The Patient presented for service on the date set forth above and was provided with a copy of Samuel T. Wood DPM Notice of Privacy Practices ("Notice"). A good faith effort was made to obtain the Patient's written acknowledgement of receipt of the Notice. However, an acknowledgement was not obtained for the following reason(s):

_____ ***Patient refused to sign acknowledgement.***

_____ ***Patient was unable to sign the acknowledgement because:***_____

_____ ***Other Reason:*** _____

Name of Employee Completing Form: _____

Signature: _____ ***Date:*** _____

Request for Electronic Access and Authorization for Email Communication

Name: _____ Email: _____

I authorize **Samuel T. Wood, DPM LLC** to contact me using the email address provided above (including my name, information regarding my account balance and instructions for accessing the patient portal).

I understand that:

- o The information is being sent for the purpose of communicating with me and allowing me to set up an account to access the patient portal,

- o My name, provider number and account balance could be viewed by anyone who has access to my email and that if my email is unsecured, the information could potentially be intercepted. (However, information in the patient portal will only be accessible to someone who has the answer to certain questions that are expected to be known only to me.), and

- o This authorization will be in force and effect until I terminate my relationship with the practice or revoke the authorization by making a request in writing to: **662 St Ferdinand, Florissant, MO 63033** ATTN: **Jody McNorton**

I further understand that:

- A revocation is effective only to the extent that the practice has not already relied upon it,

- Information used or disclosed pursuant to this authorization (name, email, practice name, account balance) may be used by a recipient of the email communication and then will be no longer protected by federal or state law,

- I can refuse to sign this authorization and the practice will not condition my treatment on whether I sign, and

- I have the right to inspect or copy my protected health information as permitted by federal and state laws.

_____ _____

Name Date