NEW PATIENT INFORMATION FORM

DATE: __/__/__ Divers license #: ______________________

NAME: Last ______________________ First ______________________ Middle ____

AGE: _____ SEX: __M __F DATE OF BIRTH: __/__/__

SOCIAL SECURITY NUMBER: ____

Primary Care Physician: ____________________ Referred By: ____________________

Pharmacy: ___________________________ Pharmacy #: ________________________

Home Address: ____

City: __________________ State: __________________ Zip: ___________________

Home Phone: ________________ Alternate phone: _____________________________

Employer: _______________________ Occupation:______________________________

Spouse's Name: ____

Primary Insurance: _______________ ID#: ____________________ Group#: ________

Cardholder: _______________________ SS#: _____________________ DOB: __/__/__

Secondary Insurance: _______________ ID#: __________________ Group #: _______

Cardholder: _______________________ SS#: _____________________ DOB: __/__/__

Emergency Contact: ____

Current Problems:

____

____

____

Length of time for current problem: ___Days ___Weeks ___Months ___Years

CURRENT MEDICATIONS

______________________ ______________________ _______________________

______________________ ______________________ _______________________

______________________ ______________________ _______________________

______________________ ______________________ _______________________

______________________ ______________________ _______________________

Are you currently taking any of the following:

__ Echinacea __Garlic __Ginger __Gingko Biloba __St. John's Wort __Ginseng __Feverfew __Ephedra

Immunization Status:

__Polio __DPT/DtaP __Measles __MMR __Hep B __Varicella

Tetanus Status: __Current __Over 5 years __Over 10 years __Unknown

Vital Signs Up to Date __________

Height __ft __in Weight _____ BP ___________ Temp. ________

Allergies:

	Penicillin		Sulfa Drugs		Aspirin		Codine
	Shellfish		Tape		Anaesthetic		Latex
	Antibiotics						

Other ____

Environmental Allergies: ____

Previous Injuries: Previous Surgeries: Previous Hospitalizations:

____________________ ___________________ ____________________

____________________ ___________________ ____________________

____________________ ___________________ ____________________

PATIENT HISTORY:

	Major Disease:		**RESPIRATORY:**		**VASCULAR:**		**Miscellaneous**
	Diabetes		Asthma		Anemia		Epilepsy
	Hypertension		Bronchitis		Sickle Cell		Thyroid Disease
	Angina		Frequent Colds		Bleeding Disorder		Muscle Disease
	Heart disease		Lung Disease		Poor Circulation		Kidney Problems
	Heart Attack		Shortness of Breath		Night Cramps		Prostate Problems
	Arrhythmia		Tuberculosis		Leg Pain if Walking		Venerial Disease
	Murmur		Emphysema		Vein Problems		Skin Condition
	Stroke				Spider Veins		Cancer History
	Chest Pain		**ARTHRITIS:**		Varicous Veins		Hepatitis
			Osteoarthritis		Swelling Problem		
	GASTROINTESTINAL:		Rheumatoid		Leg Ulceration		**Psychological:**
	Ulcers		Gout		Blood Clots		Anxiety
	Stomach Problem		Sero-negative		Transfusions		Depression
	Histal Hernia						Psychiatric Condition
	Bowel Disorder		**HEENT:**				Drug Dependence
	GI or Renal Bleeding		Headaches				Alcohol Dependence
	Acid Reflux		Eye Problems				OTHER:
			Hearing Problems				

FAMILY HISTORY:

____

SOCIAL HISTORY:

__ Married __ Single __ Divorced __Widow

Occupation: ____

Athletic Activities: ____

Alcohol ___ oz/day __oz/week Tobacco ___ pks/day __yrs

I hereby give my permission to Dr. Lyons to advise treatment and to perform such procedures as may be deemed necessary in the diagnosis and/or treatment of the extremity condition. I also hereby assign to the above named physician all benefits provided by my insurance company policy or policies for medical or surgical care. I understand that I am financially responsible for any balances on my account.

____ ________________

Signature of Responsible Party Date

OFFICE POLICY ON MANAGED CARE INSURERS

Foot Health Center of Hernando has enrolled in numerous managed care insurance programs to accommodate the needs of our patients.

With each insurance program there are many individual requirements of the plans having different stipulations regarding what services are covered and how they may be performed. These plans differ depending of what type of contract your employer has negotiated.

Because we do not have access to each employers guide lines and stipulations, we must rely on you, the patient, to inform us at the time of service exactly what those guidelines and stipulations are.

Unfortunately, if you do not inform us of special requirements in your insurance contract such as lab work, screening/preventive care, hospitalization, and/or out-patient procedures that are non-covered or must go to a specific location, or the need for a referral from your primary care physician, we have no choice but to bill you directly for those charges. Payment for those charges is then your responsibility.

Please check with your insurance if you have any questions relating to the services we provide. We want you to receive all of the benefits offered to you.

I HAVE READ AND UNDERSTAND THE OFFICE POLICY STATED ABOVE AND AGREE TO ACCEPT RESPONSIBILITY AS DESCRIBED.

____ ____________

Signature of Responsible Party Date

MEDICARE PATIENTS

I request that payment of authorized Medicare and/or insurance benefits be made on my behalf to Michael G. Lyons, DPM for any services furnished me by said physician. I authorize any holder of medical information about me to release to the Health Care Financial Administration and its agents any information needed to determine the benefits payable to related services.

__________________________________ __________________

Cardholder Signature Date

NOTICE OF PRIVACY PRACTICES
PATIENT ACKNOWLEDGEMENT

Patient Name: ____________________________________ DOB: _________________

I have received this practice's Notice of Privacy Practices written in plain language. The Notice provides in detail the uses and disclosures of my protected health information that may be made by this practice, my individual rights, how I may exercise these rights, and the practice's legal duties with respect to my information.

I understand that this practice reserves the right to change the terms of its Notice of Privacy Practices, and to make changes regarding all protected health information resident at, or controlled by, this practice. I understand I can obtain this practice's current Notice of Privacy Practices on request.

Signature: ____

Date: ____

Relationship to Patient: ____

(Dear Patients: This Privacy Statement means that we have told you that your medical and personal information will not be given to anyone unless you allow us to do so. Please do so in writing. If you have any questions, please feel free to ask.)