GENTLE TOUCH FOOT CARE

Date: _____

PATIENT INFORMATION

Patient Name: _____
First *Middle* *Last*

Home Address: _____
Street *Apartment/ Unit #*

_____
City *State* *ZIP CODE*

Home Phone: _____ Cell phone: _____

Gender: ☐ MALE ☐ FEMALE Birth Date: _____ Email Address: _____

Social Security Number: _____

Parent/ Guardian Name: (IF MINOR) _____

Emergency Contact: _____ Phone: _____

INSURANCE INFORMATION

Insured's Name: _____
First *Middle* *Last*

Relationship to Insured: ☐ SELF ☐ SPOUSE ☐ CHILD ☐ OTHER _____

Condition related to: ☐ Illness ☐ Employment ☐ Auto Accident ☐Other: _____

Birth Date: ____/_____/_____ Social Security: _____

Employer/Company Name: _____ Occupation: _____

Address: _____ Phone: _____

Insurance Company Name: _____ Policy #: _____

Secondary Insurance Name: _____ Policy #:_____

PATIENT AGREEMENT

I ASSIGN MEDICAL BENEFITS TO BRUCE THEALL, D.P.M of any and all insurances benefits for service rendered. I understand that I am financially responsible to BRUCE THEALL D.P.M for any remaining balances.

_____
Signature of Patient or Insured *Date*

I AUTHORIZE RELASE OF MEDICAL INFORMATION to my Insurance company by BRUCE THEALL, D.P.M Necessary for the processing of medical claims concerning any services rendered.

_____
Signature of Patient or Parent/Guardian *Date*

MEDICARE PATIENT'S ONLY

I REQUEST THAT PAYMENT OF AUTHORIZED MEDICARE BENEFITS BE MADE TO EITHER TO ME OR ON MY BEHALF TO DR THEALL FOR ANY SERVICES FURNISHED ME BY PHYSICIAN. I AUTHORIZE ANY HOLDER OF MEDICAL INFORMATION ABOUT ME TO RELEASE TO THE HEALTH CARE FINANCING ADMINSTRATION AND ITS AGENTS ANY INFORMATION NEEDED TO DETERMINE THESE BENEFITS OR THE BENEFITS PAYABLE FOR RELATED SERVICES

_____
Signature of Patient or Parent/Guardian *Date*

MEDICAL HISTORY

NAME: _____ DATE: _____/_____/_____

How did you hear about the office? _____

Have you ever seen a podiatrist? ☐YES ☐NO If yes, how long ago? _____

Reason for visit _____

What are your present foot problems? _____

How long have you had these problems and have you tried any OTC (over the counter) or prescription FOOT products? ☐ yes ☐ no Please List_____

Do you have or have you ever had any of the following? Please check yes or no.

Acid Reflux/Indigestion	☐Yes ☐ No	Heart Murmur	☐Yes ☐ No
Arrhythmia	☐Yes ☐ No	Hepatitis __Type	☐Yes ☐ No
Arthritis	☐Yes ☐ No	High Blood Pressure	☐Yes ☐ No
Anemia(low blood count)	☐Yes ☐ No	HIVS/AIDS	☐Yes ☐ No
Back Problems	☐Yes ☐ No	Kidney Disease	☐Yes ☐ No
Burning Sensation	☐Yes ☐ No	Liver Disease	☐Yes ☐ No
Bloodclot	☐Yes ☐ No	Numbness	☐Yes ☐ No
Cancer	☐Yes ☐ No	Pacemaker	☐Yes ☐ No
Circulatory Problems.	☐Yes ☐ No	Prostate Problems	☐Yes ☐ No
Diabetes	☐Yes ☐ No	Respiratory Disease	☐Yes ☐ No
Depression/ Anxiety	☐Yes ☐ No	Stroke/ TIA	☐Yes ☐ No
Emphysema	☐Yes ☐ No	Sciatica	☐Yes ☐ No
Epilepsy/Seizures	☐Yes ☐ No	Thyroid Problems	☐Yes ☐ No
Heart Disease	☐Yes ☐No	Tingling Sensation	☐Yes ☐ No

Family History: ☐ Heart Disease ☐ Diabetes ☐ Stroke ☐ Cancer ☐ Hypertension

Please list any operations you have had: _____

_____

Please list all your medications you are currently taking._____

_____

Are you allergic to any of the following? If yes, please check

☐ Penicillin	☐Novocaine	☐Codeine	☐Adhesive Tape	☐ NKA
☐ Aspirin	☐Shell Fish	☐Sulfa	☐ Latex	☐ Other

Height _____ Weight_____ Shoe Size _____

Social History Do you smoke? ☐YES ☐NO How Much? _____

Do you drink? ☐YES ☐NO How Much? _____

Women Only - Is there any possibility you could be pregnant ? ☐YES ☐NO

Dr.Bruce Theall, D.P.M, LLC
310 Central Ave. Suite 301
East Orange, NJ 07018

Due to the increase of patients failing to:

1. *Keep their scheduled appointments.*
2. *Cancel their appointment with adequate notice.*

Our office has implemented the following policy.

Should you have an appointment with our practice and do not give 24 hour notice to cancel and/or reschedule, you may be charged a $25.00 fee for the missed appointment. The charge is not covered by insurance and will be the responsibility of the parent/guardian if patient is a minor.

I, _____ have read the policy and understand that my insurance does not cover the charge that will be billed to me if I fail to keep my appointment or do not cancel the appointment in a timely manner.

_____ *Date:* _____/_____/_____

Patient Signature

PATIENT HIPAA ACKNOWLEDGEMENT AND DESIGNATION AND DISCLOSURE FORM

I. Acknowledgement of Practice's *Notice of Privacy Practices*:

By subscribing my name below, I acknowledge that I was provided a copy of the Notice of Privacy Practices (NPP), and that I have read (or had the opportunity to read if I so chose) and understand the Notice of Privacy Practices (NPP) and agree to its terms.

II. Designation of Certain Relatives, Close Friends and other Caregivers as my Personal Representative:

I agree that the practice may disclose certain pieces of my health information to a Personal Representative of my choosing, since such person is involved with my healthcare or payment relating to my healthcare. In that case, the Physician Practice will disclose only information that is directly relevant to the person's involvement with my healthcare or payment relating to my healthcare.

Print Name: _____ **DOB or other identifier:** _____
Print Name: _____ **DOB or other identifier:** _____
Print Name: _____ **DOB or other identifier:** _____

III. Request to receive Confidential Communications by Alternative Means:

As provided by Privacy Rule Section 164.522(b), I hereby request that the Practice make all communications to me as I have listed below:

Home Phone number: _____
[__] OK to leave a message with detailed information [__] Leave message with call back number only

Cell Phone number: _____
[__] OK to leave a message with detailed information [__] Leave message with call back number only

Work Phone number: _____
[__] OK to leave a message with detailed information [__] Leave message with call back number only

Fax Phone number: _____ [__] OK to Fax detailed information

Email Address: _____ [__] OK to email at the address provided

Mailing Address: Street: _____

City:_____ State:_____ Zip:_____

IV. The following person(s) are not authorized to receive my Patient Health Information(PHI)

Print Name: _____
Print Name: _____
Print Name: _____

The HIPAA Privacy rule requires healthcare providers to make reasonable steps to limit the use or disclosure of and requests for PHI. I understand that this accounting will not reflect disclosures that are made in the course of the Practice's ordinary health care activities related to providing patient treatment, obtaining payment for its services, or for its internal operations. Also, the Practice does not have to account for disclosures for which I have executed an Authorization permitting disclosures of my PHI.

1. The above authorizations are voluntary and I may refuse to their terms without affecting any of my rights to receive healthcare at the Practice.

2. These authorizations may be revoked at any time by notifying the Practice in writing at the Practice's mailing address marked to the attention of "HIPAA Compliance Officer."

3. The revocation of this authorization will not have any effect on disclosures occurring prior to the execution of any revocation.

4. If you request it, a copy of the information described in this form can be obtained at the front desk.

5. This form was completely filled in before I signed it and I acknowledge that all of my questions were answered to my satisfaction and that I fully understand this authorization form.

6. This authorization is valid as of the date I have signed below and shall remain valid until changed or revoked.

Name of Patient (PRINTED)	Signature of Patient	Date