COASTAL FOOT & ANKLE WELLNESS CENTER

New Patient Information and Chart Updates

(Please Print)

PLEASE COMPLETE ALL SECTIONS. – Thank You -

Date: ___________ Sex: M___ F___ DOB: __________ Email: ______________________________

Last Name: ______________________ First Name: ______________________ SSN: _______________

Street Address: __________________________ City: _____________ State: __________ Zip: __________

Home Ph#: (____)________________ Cell#: ____________________ Are You Active Military? ______

Employer Name: ____________________________________ Employer Ph#: ________________________

Occupation: ____ Full or Part-Time? ________________

Marital Status: ____ Married ____ Single ____ Divorced ____ Widowed ____ Other

Primary Language Spoken:_________________ When is the last time you saw a podiatrist? ____________

Race: __ White/Caucasion ___ Black/African-American ___ Other

Ethnicity: ___ Spanish ____ Asian ___ Other

What is Your Primary Insurance? : _______________________________ Is Policy an HMO? ___________

Name and DOB of Policy Holder if Other than Patient: ___________________________ DOB:__________

How Did You Hear About Our Office? ____

What Problem Brings You to the Office Today? ____

What is the Name of Your Primary Care Physician? ____

Do you have an Endocrinologist? If yes, what is his/her name? __________________________________
(Doctor who treats your diabetes)

Whom May We Contact In Case of Emergency?

Name: _______________________________ Ph#: ______________ Relationship: ___________________

Parent/Guardian Name (for patients under the age of 18): ____
*(*Please Note: If patient is a minor, we need the guardian's employment information completed above)*
Parent/Guardian Social Security #: ____________________________ Guardian DOB: _______________

Financial Policy for Coastal Foot & Ankle Wellness Center

All professional services rendered are charged to the patient, who is responsible for all fees, regardless of insurance coverage. Please read the following policies and ask about any questions that you may have prior to signing.

1. I hereby authorize Coastal Foot & Ankle and Wellness Center to furnish information concerning my illness and treatments to my insurance carrier(s) on my behalf.

2. I authorize the use of this form, or a copy of it, to be used on all my insurance submissions, and I authorize payment to be sent directly to Coastal Foot & Ankle.

3. If, for any reason, my insurance company denies payment-- due to deductibles or non-covered services-- I will be responsible for the amount charged by the physician for his/her services at the time of the visit.

4. If my account should fall delinquent, I understand that I will be responsible for payment of all collection costs and all legal fees.

Signature: ______________________________________ **Date**: ____________

Types of Payments Accepted

* CASH   * CREDIT CARD: Visa/Mastercard

*DEBIT CARD   * CHECK   * MONEY ORDER

IMPORTANT NOTICE:

To comply with the Federal Anti -ID -Theft Laws, we are required to scan and keep a photocopy of your driver's license or alternate government-issued photo ID as well as a copy of your insurance card(s).

New patients who present without a valid photo ID cannot be seen until such ID can be presented.

Please Note -- Your driver's license must show your current and correct home address. If it does not, we will need a copy of a current utility bill or similar statement that reflects your current address. ~ Thank You!

Please Note: **We encourage patients to sign up for our secure Coastal Patient Portal for access to all patient notes and for additional communication with the office.** -- All patients have the right to a summary printout of their visit. If you elect not to sign up for the patient portal and if you would like a copy of your visit summary before you leave, please inform the front desk and one will be printed for you.

COASTAL FOOT & ANKLE WELLNESS CENTER

PAST and PRESENT Patient Medical History

(Please Print)

PATIENT NAME: ______________________________ **/ DOB:** __________

Are You Diabetic? YES / NO **If yes, are you insulin dependent?** YES / NO

Medication Allergies: ____

___ No Known Drug Allergies ____ Allergic to Latex ____ Allergic to Tape

Food Allergies: ____

CURRENT MEDICATIONS

***** Please sign your name on the line below if you consent to our physicians obtaining your prescription information from the pharmacy database. Information received is for patient care only and the information retrieved will become a part of your HIPAA protected chart.***

Patient Signature:____

Check here _____ if you do NOT authorize us to obtain a list of medications from the pharmacy database.

*(**Please Note: In order to protect your health from potential contraindicated medication complications, our physicians will not be able to write any prescription for any patient who has not given consent to obtain a full Rx medication list**).*

Medication ______________________ Frequency ________________ Mg __________
Medication ______________________ Frequency ________________ Mg __________
Medication ______________________ Frequency ________________ Mg __________

What is Your Preferred Pharmacy?____________________ Street or Location: __________

SMOKING

Do You Smoke? YES / NO If yes, how many packs per day? _______ # of Years? _____

How soon after you wake up do you smoke? _________ Are you interested in quitting? YES / NO

DRUG USE: Do you take illegal drugs or illegal Rx medications? YES / NO

ALCOHOL: Do you drink alcohol? YES / NO If yes, how many drinks on a typical day? ______

How often did you have a drink with alcohol in it over the last year? ____________________

Are you interested in quitting? YES / NO

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PAST and PRESENT Patient Medical History

PATIENT NAME: ______________________________ **/ DOB:** ____________

Do You Have METAL in Your Body? YES / NO If yes, where? ______________________

FAMILY HISTORY *(circle all that apply)*

Mother	Heart Attack	Stroke	Diabetes
Father	Heart Attack	Stroke	Diabetes
Grandparent	Heart Attack	Stroke	Diabetes

PAST or PRESENT Illnesses *(Please circle all that apply)*

Asthma Emphysema Cancer (Type) : ______________________ Liver Disease

Hypothyroid Hyperthyroid GERD Sleep Apnea High Blood Pressure DVT

High Cholesterol Peripheral Vascular Disease Coronary Artery Disease Arrhythmias

AFIB Osteoarthritis Heart Attack (What Age?) ________ Stroke (What Age?) ________

Macular Degeneration Blindness Hearing Loss Deafness Hepatitis HIV/Aids

Polio Tuberculosis Anxiety Depression Nervousness Bipolar Disorder OCD

ADHD Schizophrenia Murmur Anemia Clotting Problem Mitral Valve Prolapse

Circulator Problems Abdominal/Aortic Aneurysm High Cholesterol Low Cholesterol

High Triglycerides Low Triglycerides COPD Eczema Psoriasis Neuropathy

Epilepsy Alzheimers Parkinsons Aneurysm Multiple Sclerosis Fibromyalgia

Rheumatoid Arthritis Osteoporosis Other: ______________________________

PAST SURGERIES / PROCEDURES: *(Please circle all that apply)*

Appendectomy Back Heart Bypass Gallbladder Hernia Hip Hysterectomy

Foot Ankle Intestinal Leg Stents Joint Replacement (What joint? ____________)

Please list anything regarding your foot / leg health (past or present) that you feel would be beneficial for the doctors to know: ____

____

Coastal Foot & Ankle Wellness Center

Authorization for Use or Disclosure of Protected Health Information

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I understand that, under the Health Insurance Portability & Accountability act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

* Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly or indirectly.
* Obtain payment from third party payers.
* Conduct normal healthcare operations such as quality assessment and physician certifications.
* *NOTE*: Information shared *will include* any alcohol/substance abuse, mental health records and history of HIV/STD as applicable unless this box is checked requesting that this info NOT be shared: ☐

I have received and/or read and understand the Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that Coastal Foot & Ankle Wellness Center has the right to change it's Notice of Privacy Practices from time to time and that I may contact Coastal at any time to obtain a current copy of the Notice of Privacy Practices.
I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand that that Coastal Foot & Ankle is not required to agree to my requested restrictions, but if agreement is made, they are bound to abide by such restrictions.

Patient Name: (please print) ____

Parent/Guardian (if patient is a minor) ____________________________________

I hereby give consent and authorize Coastal Foot & Ankle Wellness Center to allow the person(s) listed below to have access to my account information, including communication with the office staff/doctors on my behalf.

____ / Relationship: _______________

____ / Relationship: _______________

____ / Relationship: _______________

☐ I choose NOT to authorize any individual (including family) to have access to my account. (Please check)

Patient Signature: ____ / Date: ________