PETER C. SMITH, DPM, FACFAS, FACFAOM

NEW PATIENT INFORMATION FORM

1. **NAME: (Mr.) (Mrs.) (Ms.)_____**
2. **ADDRESS_____CITY_____STATE_____ZIP_____**
3. **PHONE (H) _____ (W)_____EMERGENCY_____**
4. **BIRTHDATE_____SSN _____**
5. **MEDICAL DOCTOR_____LAST VISIT_____**
6. **WHAT PHARMACY DO YOU USE?_____**
7. **EMPLOYER_____OCCUPATION_____**
8. **MARRIED_____ SPOUSE NAME_____**
9. **HOW DID YOU HEAR ABOUT THE OFFICE/WHO REFERRED YOU?_____**

INSURANCE INFORMATION (We will copy your insurance cards)

1. PRIMARY INS._____

Subscriber's Name_____ Relationship to Subscriber_____

Subscriber's DOB: _____ Subscriber's SSN _____

2. SECONDARY INS._____

Subscriber's Name_____ Relationship to Subscriber_____

Subscriber's DOB : _____ Subscriber's SSN _____

CONSENT TO TREAT

I give permission for Peter C. Smith, DPM to examine and treat my feet or ankles, medically, orthopedically or surgically as he deems necessary after he has discussed my condition with me. I also give Dr. Smith permission to perform minor surgical procedures as may be deemed necessary in the diagnosis and treatment of my condition.

ASSIGNMENT OF BENEFITS

I authorize my insurance company to directly pay Peter C. Smith, DPM for my medical and surgical claims. I also authorize the release of any information to my insurance company necessary to process these claims.

MEDICARE PATIENTS

I request that payment of authorized Medicare/Medigap benefits be made either to me or on my behalf to the name of provider of service and (or) supplier for any services furnished to me by that provider of service and (or) supplier. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services and its agents any information needed to determine these benefits or the benefits payable for related service

PATIENT SIGNATURE_____DATE_____

PARENT/GUARDIAN SIGNATURE_____DATE_____

PRINT PARENT/GUARDIAN NAME_____

PRESENT FOOT/ANKLE PROBLEM

1. **Describe present problem:**_____
2. **When did it start?** _____
3. **What make it worse?**_____
4. **Have you seen a Podiatrist before, if so when?**_____
5. **ARE YOU UNDER HOSPICE CARE?**_____
   OFFICE USE ONLY: ABN (Yes NO)

PAST MEDICAL HISTORY

4. **List all allergies:**_____
5. **Current medications you take:**_____

   _____
6. **Are you currently seeing your physician on a regular basis?**_____
7. **Do you have or have you had any of the following:**

_____Diabetes (IDDM/NIDDM)	**____High Blood Press**	**_____Heart Surgery**
_____Mitral Valve Problems	**____Heart Attack/Angina**	**_____Circulation Disorder**
_____Varicose Veins	**____Phlebitis**	**_____Anemia**
_____Epilepsy/Seizures	**____Stomach Ulcer**	**_____Neuropathy**
_____Rheumatic Fever	**____Scarlet Fever**	**_____Artificial Joints**
_____Liver Disease	**____Hepatitis**	**_____Jaundice**
_____Lung Disease	**____Tuberculosis**	**_____Asthma**
_____Kidney Disorders	**____Cancer**	**_____Gout**
_____Arthritis	**____Thyroid Condition**	**_____Scarring Tendency**

8. **Other Conditions:**_____

   _____
9. **Past Surgeries:**_____

   _____
10. **If female: Are you pregnant? _____Past pregnancies? _____ Complications? _____**
11. **Family History: ____Diabetes _____Heart Disease _____Stroke _____Hypertension**
    ____Cancer _____Arthritis _____Other
12. **Do you: ____Smoke How much?_____ Drink coffee/tea _____How much?_____**
    ____Drink alcohol How much?_____
13. **Exercise/Fitness Routine (miles/days per week/ how long etc)** _____

    _____
14. **Type of work:** _____**How long at present job?**_____
15. **Type of shoes worn most often:** _____

ALL INFORMATION IS STRICTLY CONFIDENTIAL IN ACCORDANCE WITH HIPAA POLICY

Peter C. Smith, DPM
HIPAA Privacy, Assignment of Benefits and Financial Policy Agreement

HIPAA Policy (Privacy Policy)

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read if I so chose) and understand this notice.

I understand that my medical information can be released to my family doctor or other medical specialist, my insurance company or as otherwise authorized under the HIPAA guidelines. I additionally authorize Dr. Smith to release my information to:

_____

Name ***Relationship***

_____

Name ***Relationship***

_____

Name ***Relationship***

CONSENT TO TREAT

I give permission for Peter C. Smith, DPM to examine and treat my feet or ankles, medically, orthopedically or surgically as he deems necessary after he has discussed my condition with me and I consented to the treatment. I also give Dr. Smith permission to perform minor surgical procedures as deemed necessary in the diagnosis and treatment of my condition.

ASSIGNMENT of BENEFITS

I authorize my insurance company to directly pay Peter C Smith, DPM for my medical and surgical claims performed by him or his associates. I also authorize the release of my medical information as necessary to process these claims.

MEDICARE ASSIGNMENT of BENEFITS

I request that payment of authorized Medicare/Medigap or any agents thereof be made either to me or on my behalf to the name of the provider of service and or supplier for any services furnished to me by that provider of service and or supplier. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services and its agents any information needed to determine these benefits or the benefits payable for the related services.

FINANCIAL POLICY of Dr. Peter C. Smith

I have been furnished a copy of, or have read the Financial Policy of Peter C. Smith and understand all the terms, conditions and requirements applicable to my payment obligations to Dr. Peter C. Smith, DPM.

Print Name:_____

Print Responsible Party:_____

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