COLUMBUS FOOT CLINIC
2221 5TH STREET NORTH
COLUMBUS, MS 39705
PH: (662)244-8585 FAX: (662)245-1122

DATE: _____

FIRST NAME_____ LAST NAME_____MIDDLE INITIAL_____

DATE OF BIRTH_____AGE_____ SEX M/F SS#_____

STREET
ADDRESS_____

CITY_____ STATE_____ ZIP_____

HOME PHONE_____ CELL PHONE_____ WORK PHONE_____

E-MAIL ADDRESS_____

INSURANCE INFORMATION

PRIMARY INSURANCE _____ INSURED NAME_____

DATE OF BIRTH_____ RELATIONSHIP TO PATIENT_____

SECONDARY INSURANCE _____INSURED NAME_____

DATE OF BIRTH_____RELATIONSHIP TO PATIENT_____

PRIMARY CARE PHYSICIAN

DR. NAME_____ DATE OF LAST VISIT_____

LAST A1C TEST _____

ADDRESS_____ PHONE NUMBER_____

PHARMACY

NAME: _____

PATIENT EMERGENCY CONTACT

NAME_____ RELATIONSHIP_____PHONE_____

NAME_____RELATIONSHIP_____PHONE_____

PODIATRIC HISTORY

What is the chief complaint for which you came to be treated?_____

How long has this problem been bothering you?_____ Shoe Size _____ Weight _____ Height_____

Have you ever been to a Podiatrist before? Yes No If yes, name_____

Is there any personal or family history of diabetes? Yes No

Years Smoked? _____ Years Drinking? _____

Athletic Activities in which you participate? _____

***Please indicate which foot problems you now have or have had in the past.**

Ankle pain	yes	no	Athlete's Foot	yes	no	Plantar warts	yes	no
Corns/Calluses	yes	no	Flat Feet	yes	no	Numbness in feet/legs	yes	no
Heel Pain	yes	no	Ingrown Toenails	yes	no	Other _____		
Bunions	yes	no	Foot/Leg Cramps	yes	no	_____		

MEDICAL HISTORY

Circle "yes" or "no" to indicate if you have had the following:

AIDS/HIV	yes	no	Dialysis	yes	no	Psychiatric Care	yes	no
Allergies to Anesthetics	yes	no	Ear Problems	yes	no	Radiation Treatment	yes	no
Allergies to Medicine	yes	no	Epilepsy	yes	no	Rash	yes	no
Drug User	yes	no	Eye Problems	yes	no	Respiratory Disease	yes	no
Anemia	yes	no	Fainting	yes	no	Rheumatic Fever	yes	no
Angina	yes	no	Foot/Leg Cramps	yes	no	Shortness of Breath	yes	no
Arthritis	yes	no	Gout	yes	no	Sinus Problems	yes	no
Artificial Heart Valves of Joints	yes	no	Headaches	yes	no	Special Diet	yes	no
Asthma	yes	no	Heart Disease	yes	no	Stroke	yes	no
Back Problems	yes	no	Hemophilia	yes	no	Swelling in Ankles, Feet	yes	no
Bleeding Disorders	yes	no	Hepatitis/ Jaundice	yes	no	Swollen Neck Glands	yes	no
Cancer	yes	no	High Blood Pressure	yes	no	Tired Feet	yes	no
Chemical Dependency	yes	no	Kidney Problems	yes	no	Tuberculosis	yes	no
Chest Pain	yes	no	Liver Disease	yes	no	Ulcers	yes	no
Chronic Diarrhea	yes	no	Low Blood Pressure	yes	no	Varicose Veins	yes	no
Circulatory Problems	yes	no	Nervous Problems	yes	no	Venereal Disease	yes	no
Diabetes	yes	no	Phlebitis	yes	no	Weight Loss, unexplained	yes	no

Surgeries you have had: _____

_____

Have you taken the Flu shot? Yes No **Pneumococcal Vaccination Yes No**

MEDICATIONS

Please list all prescriptions, over the counter medication and vitamins:

_____

_____

_____

ALLERGIES

_____

_____

CONSENT

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

Signature_____ **Date**_____

COLUMBUS FOOT CLINIC
2221 5TH ST. N. COLUMBUS, MS 39705
PH# 662-244-8585 FAX# 662-245-1122

Notification of Information Practices

The purpose of the consent form is to inform you, the patient, how your personal health information is used and/or disclosed by Columbus Foot Clinic. We want you to be fully aware of what we do with your information so that you can provide us with your consent in order for us to treat your health care needs, receive payment for services rendered, and allow administrative and other types of health care operations to happen, which are part of normal business activities of Columbus Foot Clinic.

Your consent

I understand that as part of my health care, Columbus Foot Clinic originates and maintains health records describing my health history, symptoms, test results, diagnoses, treatment, and 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 my diagnosis/es and other health information to my bill(s).
- A source of information for applying my diagnosis/es and other health information to my bill(s).
- A means by which my health plan or health insurance company can verify that services billed were actually provided.
- A tool for routine health care operations at Columbus Foot Clinic, such as ensuring that we have quality processes and programs in place and making sure that the professionals who provide your care and competent to do so.

I understand that:

- I have been provided with a Notice of Information Practices that provides specific examples and descriptions of how my personal health information is used and discloses by Columbus Foot Clinic;
- I have the right to review the Notice of Information Practices prior to signing this consent;
- Columbus Foot Clinic, Inc can change its Notice of Information Practices but notify me of those changes before they are put into practice and will mail me a copy of the new Notice to the address that I have provided;
- I have 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 and that Columbus Foot Clinic, Inc. is not required to agree to those restrictions;
- Any restrictions to which Columbus Foot Clinic agrees to will be respected.

COLUMBUS FOOT CLINIC
2221 5TH ST. N. COLUMBUS, MS 39705
PH# 662-244-8585 FAX# 662-245-1122

- I may revoke this consent in writing at any time. Further, I am aware that Columbus Foot Clinic can proceed with uses and disclosures that pertain to treatment, payment, or healthcare issues that took place before the consent was revoked.

To request a restriction on the use and disclose of your personal health information related to your treatment, payment for service, or for the health care operations of Columbus Foot Clinic please do so after reading the Notice of Information Practices. You may use this consent form to request a restriction. If you have any questions, comments, or complaints, please contact our office.

I request the following restrictions to the use or disclosure of my health information.

For provider use only:
Restriction is
☐ Accepted
☐ Denied
Reason denied:
Patient is notified?
☐ Yes
☐ No

Please provide your signature below to indicate that you have read the above consent and have reviewed the Notice of Information Practices.

_____ _____
Signature of Patient or Legal Representative Witness

_____
Legal Representative/Printed Name/Relationship/Why the Patient Cannot Sign

_____ _____
Date Effective Date