

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 _____

*****Best way to contact you CALL – EMAIL – TEXT*****

GUARANTOR INFORMATION

PRIMARY 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 _____

Answer all Questions by stating Yes or No

1. Are you experiencing any of the following:

- | | | |
|-----------------------------|-------------------|------------------------|
| Left or Right foot pain Y N | Flat Feet Y N | Bunions R/L Y N |
| Ankle Sprains Y N | Calluses Y N | Backaches Y N |
| Ingrown toenails Y N | Thick Nails Y N | Warts Y N |
| Feet/Leg Cramping Y N | Pain in Heels Y N | Swollen Ankle/foot Y N |
| Corns Y N | Knee Pain R/L Y N | Poor Circulation Y N |

2. Date of Last Physical Exam: ___/___/___ Physician Last: _____

3. List all Surgeries with Dates: _____

4. DO YOU HAVE OR HAVE YOU EVER BEEN TREATED FOR ANY OF THE FOLLOWING

- | | | |
|---------------------------|-------------------------|------------------------|
| Anemia Y N | Heart Attack Y N | Phlebitis Y N |
| Asthma Y N | Hepatitis Y N | Rheumatic Fever Y N |
| Arthritis Y N | High Cholesterol Y N | Shortness Breath Y N |
| Cancer Y N | High Blood Pressure Y N | Sickle Cell Anemia Y N |
| Diabetes Y N | Immune Dis./HIV Y N | Stroke Y N |
| Difficulty in healing Y N | Injury/Accident Y N | Thyroid Disease Y N |
| Depression/anxiety Y N | Kidney Bladder Y N | Tuberculosis Y N |
| Epilepsy/Seizures Y N | Liver Disease Y N | Vascular Disease Y N |
| Heart Disease Y N | Lung Disease Y N | |

5. Have you experienced any effects or allergic reaction from any of the following:

- | | | |
|----------------|---------------|-----------------|
| Penicillin Y N | Novocain Y N | Latex Y N |
| Aspirin Y N | Lidocaine Y N | Peanuts Y N |
| Cortisone Y N | Codeine Y N | Sulfa Drugs Y N |

ANY OTHER MEDICINES, ETC.: _____

6. Are you currently taking any medications? Y N If so, list all medications you are currently taking. **THE DOCTOR WILL NOT BE ABLE TO SEE YOU WITH OUT A LIST OF YOUR MEDICINE.....**

7. Is there a family History of:

- | | | |
|--------------------------|-------------------------|------------------------------|
| Diabetes Y N | High Blood Pressure Y N | Problems with Anesthesia Y N |
| Circulatory Problems Y N | Bleeding Disorders Y N | |

8. Do you have a Social History of:

- Tobacco (pkg/day___) Y N Coffee (cups/day___) Y N Alcohol Y N
Substance Abuse (describe) Y N _____

9. WOMEN ONLY: Are you pregnant, or is there any chance you might be? Y N

Are you nursing Y N Last Menstrual Cycle: _____
Are you on Oral Contraceptives, it is important that you understand that antibiotics (and other medications) may interfere with the effectiveness of oral contraceptives. Therefore, you will need to use mechanical forms of birth control for one complete cycle of birth control pills, after the course of antibiotics or other medication is completed.
PLEASE CONSULT W/YOUR PHYSICIAN FOR FURTHER GUIDANCE.

10. Review of Systems: (any problems with in the last 2-3 mths)

HEENT _____ Gastrointestinal _____ Cardiovascular _____ Locomotor _____
Genitourinary _____ Neuropsychiatric _____ Respiratory _____

REVIEWED BY: Initials: _____ Date: _____

PRIVACY

Our practice is obligated to protect the privacy of your health information. Therefore, we will not release information regarding your appointments, account information, insurance, etc. during telephone conversations, etc., to anyone unless you authorize us to do so by printing the names of those people below: I hereby authorize FSMS to release information to myself and the following person or persons (i.e.: mother, father, husband, etc.) and accept that FSMS, does not have the ability to verify the identity of individuals who call requesting information.

Name/Address/Phone #: _____ DOB: _____ Relationship: _____
Name/Address/Phone #: _____ DOB: _____ Relationship: _____

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I hereby acknowledge that I have been given the opportunity to read a copy of this practice's Notice of Privacy Practice. I have been given the opportunity to ask any questions I may have regarding this Notice.

Signature/Relationship Date

FEES & PAYMENTS

Fees are payable at the time services are rendered. Regardless of form of payment, consult fees are due on appointment day. **Please know that there is a fee of \$25.00 for a NO SHOW/ NO CALL for ALL APPOINTMENTS. This is not filed to your insurance.** We will be glad to file for reimbursement with your insurance company after your appointment. An estimate of the charge for any procedure or surgery will be required prior to surgery after insurance benefits are checked by our staff. Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. It is your responsibility to pay any deductible amount, co-insurance or any other balance not paid for by your insurance company upon appointment. This signature on file is my authorization for the release of information necessary to process my claim. I hereby authorize payment to this doctor named of the benefits otherwise payable to me and certify by signing that I am responsible for the balance of this account. Payments are due and payable at Creditor's place of business as shown on the bills, statements, and at Creditor's office at 2221 5th Street North Columbus, MS 39705.

Signature of person responsible for account

CONSENT FOR TREATMENT

I understand the importance of a truthful Health History to assist the doctor in providing the best care possible, I certify that I have read and understand the questions above. I acknowledge that my questions, if any, about the inquires set forth above have been answered to my satisfaction. I will not hold my Doctor, or any other member of his staff, responsible for any errors or omissions that I have made in the completion of this form.

I authorize the physician, mid-level providers, and clinic to perform or administer such tests, treatments, medications, anesthesia or other medical/surgical treatment as deemed necessary or advisable in the diagnosis or treatment of this patient.

Date Signature of Person Completing Health History Consent/patient Relationship