PATIENT INFORMATION Today's Date: _______________

Name: Last______________________ First _______________________ Middle ____

Address: _____________________ City: _________________ State: ___ Zip: ________

Date of birth: _______________ Age ___ Sex:_____ Social Security: ___________
Marital Status: S__ M__ D__ W__

Place of employment_______________________Occupation: ______________________

Home Phone: ( ) ___________________ Work Phone: ( ) _____________

Emergency Phone: _______________Relationship to Patient: ______________________

RESPONSIBLE PARTY INFORMATION

Who is Responsible for Payment of this Account? __________________________________

Relationship to Patient: _____________________ Social Security: _________________

Occupation: _____________Employer: _________________ Work Phone: ___________

INSURANCE INFORMATION

Does your insurance require referrals? Yes ___ No ___

Primary Insurance Co: ______________________________ Phone: ________________

Address: ____

Insured Party: ____________________ Rel. to Patient: ______________ DOB: ______

Subscriber ID#: ________________________ Group #: _________________________

Group#: __________________ Social Security# of insured: _______________

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Secondary Insurance Co.: __________________________ Phone: __________________

Address: ____

Insured Party: __________________ Rel. to Patient: ____________ DOB: ___________

Subscriber ID# ______________________ Group #: _______________________

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Workers Compensation Claim # (if applicable): __________ Date of Injury? _________

Referred by: ____

Primary Care Physician: ____

Have you been seen by a podiatrist in the last year? If yes, what were you treated for?

Are you a Diabetic? Yes __ No __

Are you a known bleeder? Yes __ No __

Do you take blood thinners? Yes __ No __

Are you allergic to any medications? Yes __ No __
If so , which ones: ____
____

What medications are you taking?____
____

Have you ever been treated for heart trouble, asthma, epilepsy, rheumatic fever, kidney or liver trouble? ____

Have you had any serious operations? ____
____

Do you heal quickly when cut or scratched? Yes __ No __

Are you HIV positive? Yes __ No __

Have you ever had any foot care? ____

Describe your foot complaint? ____

How long have you had this condition? ____

Did this condition begin suddenly or gradually? _______________________________________

Is it getting worse? ____

Is it worse at certain times of the day? ____

Is it worse while standing or walking? ____

Worse while wearing shoes? ____

How would you describe the pain? ____

Leg and/or foot cramps? ____

Familial history of foot trouble? ____

AUTHORIZATION FOR RELEASE OF PRIVATE HEALTHCARE INFORMATION

By signing this document, I agree to release of medical information and any other private healthcare information between Dr. Theodore Bowlus, D.P.M., Inc. and any physician or provider of medical services and/or medical equipment deemed necessary by Dr. Bowlus to assist in the treatment of my medical condition. I also authorize release of my private healthcare information to my medical insurance company or companies and any other business affiliates of Dr. Theodore Bowlus, D.P.M., Inc., as necessary, to facilitate the filing and payment of medical claims filed on my behalf.

____ _______________

Patient's Signature (or responsible party if a minor) Date

ASSIGNMENT OF INSURANCE BENEFIT

By signing this document, I authorize my insurance company to pay an applicable insurance benefits directly to Dr. Theodore Bowlus, D.P.M., Inc., realizing that I am ultimately responsible for any charges not covered by my insurance plan or plans, as required by my contract with my insurance company, or as specifically agreed between me and Dr. Theodore Bowlus, D.P.M., Inc.

____ _______________

Patient's Signature (or responsible party if a minor) Date

MEDICARE PATIENTS ONLY

I request that payment of authorized Medicare Benefits be made on my behalf to the physician, Dr. Theodore Bowlus, D.P.M., Inc., for any services furnished to me by Dr. Bowlus. I authorize release to the Health Care Financing Administration and its agents any medical information about me that is needed to determine the payments for my medical treatment and any related services.

____ _______________

MEDICARE BENEFICIARY'S NAME DATE

Under, the HIPAA privacy rule, patients have the right to request confidential communications or that a communication of protected health information (PHI) be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home. Please indicate on this form how you wish to be contacted:

I WISH TO BE CONTACTED IN THE FOLLOWING MANNER (check all that apply):

ORAL COMMUNICATION:

___ Home telephone _______________
- ____ O.K. to leave message with detailed information.
- ____ Leave message with call-back number only.

___ Work telephone _______________
- ____ O.K. to leave message with detailed information.
- ____ Leave message with call-back number only.

____ Other: ____

WRITTEN COMMUNICATION:

___ O.K. to mail to my home address
___ O.K. to mail to my work/office address
___ O.K. to fax this number ___________________
___ Other:__________________________________

ADDITIONAL COMMUNICATION:

___ I permit the Practice to discuss my PHI with and to disclose my PHI to, the following individuals:
- ___ My spouse __________________________
- ___ My adult child(ren)____________________
- ___ My personal relative __________________

___ Other ______________________________

COMMENTS:

____

____

PATIENT OR GUARDIAN SIGNATURE **DATE**

X___________________________________ _________________________

ACKNOWLEDGMENT OF RECEIPT

OF
NOTICE OF PRIVACY PRACTICE

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

______________________________________ ____________________
Patient Name (Please Print) Date

____
Parent or Authorized Representative (if applicable)

____
Signature