FEET FIRST, PLLC/C. LYNN ROSENBAUM, D.P.M **NEW PATIENT FORMS**

PATIENT INFORMATION

First and Last Name: _____ MI: _____ DOB:_____ Age:_____

Sex: M ☐ F ☐ SS#: _____ - _____ - _____ Cell Phone: _____

Address: _____ Work Phone: _____

City: _____ State: _____ Zip: _____ Home Phone: _____

May we call the phone #'s provided above and/or leave a voicemail? Yes ☐ No ☐ With whom may we speak to regarding your medical

May we send you text messages? Yes☐ No ☐ information? _____

May we send you emails? Yes ☐ No ☐ Email: _____

Emergency Contact Name: _____ Pharmacy Name: _____

Relationship: _____ Pharmacy Phone #: _____

Phone #: _____ Primary Care Dr.:_____

How did you hear about us? _____ Primary Care Phone #: _____

_____ Last Date Seen: Month: _____ Day: _____ Year:_____

INSURED INFORMATION

Primary Insurance: _____

Secondary Insurance: _____

Employer: _____ Occupation: _____

SOCIAL HISTORY

Marital Status	Use of Alcohol	Use of Tobacco	Diabetics	Age 65+ only
☐Single ☐Married ☐Partnered ☐Separated ☐Divorced ☐Widowed	☐Never ☐Rare ☐Occasional ☐Moderate ☐Daily ☐No Longer Use ☐History of Alcohol Abuse	☐Never ☐<5 Cigarettes per day ☐½ pack per day ☐1 pack per day ☐>1 pack per day How many years?_____ ☐Quit – How long ago? _____ Type: _____	Pre-Diabetes ☐ Type 1 Diabetes ☐ Type 2 Diabetes ☐ Physician: _____ Last Office Visit: _____ /_____ /_____ HbA1C: _____% Date Drawn: _____ /_____ /_____	Have you had a fall in the past year? Y ☐ N ☐ Were you injured? Y☐ N☐ Have you had 2 or more falls in the past year? Y☐ N ☐

Dependents	Use of Recreational Drugs	Measurements	Exercise	
☐Children – Age(s):_____ ☐Pet(s) – What kind? _____ ☐Elderly or Disabled family ☐Other: _____ _____	☐Never ☐Rare ☐Occasional ☐Moderate ☐Daily Type: _____ _____	Height: _____ Weight: _____ Shoe size: _____ Shoe type: _____	☐Never ☐Rare ☐Occasional ☐Weekly ☐Several times per week ☐Daily Type: _____ _____	Do you use any of the following to assist with walking? ☐Cane ☐Walker ☐Wheelchair ☐Crutches ☐None

Patient Name: _____

Do You Have a Family History of: ☐None		Surgical History: ☐None	
☐Diabetes Type 1 or 2	☐Heart Disease	Surgery:	Date:
☐Cancer	☐High Blood Pressure		
☐Stroke	☐Thyroid Disease		
☐Coronary Artery Disease	☐Rheumatoid Arthritis		
Other: _____			

Please list all medications you are currently taking: (Including prescriptions, over-the-counter vitamins/herbal supplements)

Current Medications: ☐None			Allergies: ☐None		
Medication name:	Dosage:	How often?	☐Penicillin	☐NSAIDs	☐Latex
			☐Sulfa Drugs	☐Aspirin	☐Steroids
			☐Codeine	☐Iodine	☐Shellfish
			☐Morphine	☐Adhesive Tapes	☐General/Local Anesthetics
			Other: _____		

Describe your main issue:	What specific issue brings you to the office today? _____ Which Foot? _____ Is one side worse than the other? ☐ Y ☐ N If yes, which side? _____ How long ago did this issue start? _____ Days / Weeks / Months / Years
Describe your pain:	Did your pain or issue: ☐ Begin all of a sudden ☐ Gradually develop over time How would you rate your pain on a scale of 0 to 10? (Please Circle) (No Pain) 0 1 2 3 4 5 6 7 8 9 10 (Worst Pain Possible) How would you describe your pain? ☐ No Pain ☐ Sharp ☐ Dull ☐ Aching ☐ Burning ☐ Radiating ☐ Itching ☐ Stabbing ☐ Other:_____
What treatment have you done:	Since the time your pain or issue began, has it? ☐ Stayed the Same ☐ Become Worse ☐ Improved What makes your pain or issue feel worse? ☐ Walking ☐ Standing ☐ Daily Activities ☐ Resting ☐ Dress Shoes ☐ High Heels ☐ Flat Shoes ☐ Any Closed Toe Shoes ☐ Running ☐ Other: _____ What makes your pain better? _____ What treatment have you had for this condition? _____
How has this affected you:	How has this issue affected your lifestyle or ability to work? _____ Was this issue caused by an injury? ☐ Yes ☐ No (Describe if yes) _____ If yes, was it a work-related injury? ☐ Yes ☐ No

Patient Name: _____

Past Medical History/Review of Systems (check all that apply) ☐ None

Major Illness:
- ☐Diabetes Type 1 or 2
- ☐Heart Disease
- ☐Hypertension
- ☐Chest Pain Angina
- ☐Heart Attack
- ☐Cancer
- ☐Mitral Valve Prolapse
- ☐Murmur
- ☐Arrhythmia
- ☐Congestive Heart Failure
- ☐Pacemaker

Respiratory:
- ☐Asthma
- ☐Bronchitis
- ☐Emphysema
- ☐Frequent Colds
- ☐Shortness of Breath
- ☐COPD
- ☐Lung Disease or Breathing Problems
- ☐Tuberculosis
- ☐Smoker

Skin Disorders:
- ☐Psoriasis
- ☐Skin Cancer
- ☐Dry Skin
- ☐Painful Scars
- ☐Nail Abnormalities
- ☐Ulcers on Feet/Legs

EENT:
- ☐Sinus Problems or Infections
- ☐Tonsillitis
- ☐Throat Infections
- ☐Glaucoma
- ☐Cataracts
- ☐Eye or Vision Problems
- ☐Headaches
- ☐Migraines
- ☐Ear Infections
- ☐Hearing Deficit

Gastrointestinal:
- ☐Ulcers
- ☐Reflux
- ☐Hiatal Hernia
- ☐Stomach Disorder
- ☐Bowel Disorder
- ☐Irritable Bowel Syndrome
- ☐Hemorrhoids
- ☐GI or Rectal Bleeding
- ☐Rectal Fissures

Genitourinary:
- ☐Kidney or Bladder Infections
- ☐Kidney Stones
- ☐Decreased Kidney Function
- ☐Prostate
- ☐STD

Vascular Disease/ Blood Disorders:
- ☐Poor Circulation
- ☐PVD
- ☐Leg/Calf Pain
- ☐Night Cramps
- ☐Rest Pain
- ☐Vein Problems
- ☐Swelling
- ☐Spider Veins
- ☐Varicose Veins
- ☐Phlebitis
- ☐Leg Ulcers
- ☐Blood Clots
- ☐Deep Vein Thrombosis
- ☐Pulmonary Embolism
- ☐Bleeding/Clotting Disorders
- ☐Easy Bruising
- ☐Anemia
- ☐Sickle Cell
- ☐Transfusions

Arthritis:
- ☐Rheumatoid
- ☐Osteo
- ☐Gout
- ☐Other:_____

_____

_____

MSK/Neuro:
- ☐Back Pain
- ☐Joint Pain
- ☐Joint Stiffness
- ☐Joint Swelling
- ☐Leg Cramps
- ☐Cold Feet
- ☐Numb Feet
- ☐Tingling Feet
- ☐Burning Feet

Psychological:
- ☐Anxiety
- ☐Depression
- ☐Psychiatric Disorder
- ☐Drug or Alcohol Dependency

Misc:
- ☐Epilepsy/Seizures
- ☐Thyroid Disorder
- ☐Muscle Disease
- ☐Tremors
- ☐Hepatitis
- ☐HIV or AIDS
- ☐Lyme Disease
- ☐Current Pregnancy
- ☐Current Breast-feeding

Other:

Please describe: _____

_____

_____

DEPRESSION SCREENING: (AGES 12 AND UP)

Have you ever been diagnosed with depression or currently taking medication for it? Yes No

If the answer is no, how often have you been bothered by the following over the past 2 weeks?

	0	1	2	3
Little interest or pleasure in doing things?	Not at all	Several Days	More than half the days	Nearly every day
Feeling down, depressed or hopeless?	Not at all	Several Days	More than half the days	Nearly every day
Trouble falling or staying asleep or sleeping too much?	Not at all	Several Days	More than half the days	Nearly every day
Feeling tired or having little energy?	Not at all	Several Days	More than half the days	Nearly every day
Poor appetite or overeating?	Not at all	Several Days	More than half the days	Nearly every day
Feeling bad about yourself or that you're a failure?	Not at all	Several Days	More than half the days	Nearly every day
Trouble concentrating on things such as reading or tv?	Not at all	Several Days	More than half the days	Nearly every day
Fidgety or restless/moving a lot more than usual?	Not at all	Several Days	More than half the days	Nearly every day
Thought of hurting yourself in some way?	Not at all	Several Days	More than half the days	Nearly every day

To the best of my knowledge, I have answered the questions on this form accurately. I understand that providing incorrect information can be dangerous to my health. I understand that it is my responsibility to inform the doctor and office staff of any changes in my medical status.

_____ _____

Patient/Guardian Signature Date

Patient Name: _____

Patient HIPAA Consent Form

By signing this form, you are granting consent to Feet First, PLLC to use and disclose your protected health information for the purposes of treatment, payment and health care operations. Our Notice of Privacy Practices provides more detailed information about how we may use and disclose this protected health information. You have a legal right to review our Notice of Privacy Practices before you sign this consent, and we encourage you to read it in full. Our Notice of Privacy Practices is subject to change. If we change our notice, you may obtain a copy of the revised notice by contacting us at (931) 854-9222. You have a right to request us to restrict how we use and disclose your protected health information for the purposes of treatment, payment or health care operations. We are not required by law to grant your request. However, if we do decide to grant your request, we are bound by our agreement. You have the right to revoke this consent in writing, except to the extent we already have used or disclosed your protected health information in reliance on your consent.

_____ _____

Patient/Guardian Signature Date

SURESCRIPTS CONSENT FORM

I authorize Feet First, PLLC to electronically obtain access to my prescription history from participating pharmacies through the Surescripts network. This will assist Feet First, PLLC providers with prescribing, assessing health conditions and recommending appropriate treatment.

I understand that this consent will remain in effect until I am terminated in writing as a patient of this practice or until I submit a written request to revoke this consent to the practice. However, any disclosures that occurred prior to the date of revocation will not be affected.

_____ _____

Patient/Guardian Signature Date

EMAIL / TEXT INFORMED CONSENT FORM

I understand that the information sent to me via email and/or via text message from persons at Feet First, PLLC will not be sent securely and will be unencrypted. I understand the risks associated with that including, but not limited to, that my PHI may be read by an unintended third party. I have been notified of the risks. I understand said risks and I still prefer to receive protected health information via unsecure communications via email and text message. I understand that Feet First, PLLC and its staff are not responsible for any unauthorized access of my protected health information communicated by way of unencrypted email and text and that I bear the risk.

_____ _____

Patient/Guardian Signature Date

Patient Financial Policy

Your understanding of our financial policies is an essential element of your care and treatment. If you have any questions, please discuss them with our front office staff or supervisor.

- As our patient, you are responsible for all authorizations/referrals needed to seek treatment in this office.
- Unless other arrangements have been made in advance by you, or your health insurance carrier, payment for office services are due at the time of service. We will accept Visa, MasterCard, Discover, cash or check.
- A service charge may be applied to all credit card purchases. To avoid this fee, you may pay with cash or check
- Your insurance policy is a contract between you and your insurance company. As a courtesy, we will file your insurance claim for you if you assign the benefits to the doctor. In other words, you agree to have your insurance company pay the doctor directly. If your insurance company does not pay the practice within a reasonable period, we will have to look to you for payment.
- We have made prior arrangements with certain insurers and other health plans to accept an assignment of benefits. We will bill those plans with which we have an agreement and will only require you to pay the co-pay/co-insurance/deductible.
- If you have insurance coverage with a plan with which we do not have a prior agreement, we will prepare and send the claim for you on an unassigned basis. This means your insurer will send the payment directly to you. Therefore, all charges for your care and treatment are due at the time of service.
- All health plans are not the same and do not cover the same services. In the event your health plan determines a service to be "not covered," or you do not have an authorization, you will be responsible for the complete charge. We will attempt to verify benefits for some specialized services or referrals; however, you remain responsible for charges to any service rendered. Patients are encouraged to contact their plans for clarification of benefits prior to services rendered.
- You must inform the office of all-insurance changes and authorization/referral requirements. In the event the office is not informed, you will be responsible for any charges denied.
- For most services provided in the hospital, we will bill your health plan. Any balance due is your responsibility.
- There are certain elective surgical procedures for which we require pre-payment. You will be informed in advance if your procedure is one of those. In that event, payment will be due one week prior to the surgery.
- Past due accounts if your account becomes sixty days past due, further steps will be taken to collect the debt. If the account is referred to a collection agency, you agree to pay your balance plus a $50 collection fee and any additional collection costs that are incurred. If collection of the balance of your account is turned over to a lawyer, you agree to pay all lawyer fees which are incurred plus court costs. In case of suit, you agree the venue shall be Putnam County, Tennessee. In addition, we reserve the right to deny future non-emergency treatment for any and all debtor-related unpaid account balances.
- There is a service fee of $25.00 for all returned checks. Your insurance company does not cover this fee.
- All appointments that need to be cancelled should be done 24 hours prior to the appointment. If you fail to provide 24 hours' notice to cancel the appointment or do not come in for your appointment, you can be charged a fee of $25.00.
- There will be a charge for all medical records printed. A $25.00 fee for the first 5 pages and $0.50 per page for each page thereafter. Please allow ample time (1 week) to be completed.
- There will be a fee of $25.00 to complete disability/FMLA paperwork, per set. Please allow ample time (1 week) to be completed.
- Copies of x-rays can be made for a fee of $5.00 per disc when requested by a third party.

_____ _____

Patient/Guardian Signature Date