|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Lansing Podiatry, PLLC | |  | **PATIENT DEMOGRAPHICS** | | | | | |  | Print Date | 10/3/2018 |
| 1500 Watertower Place Ste 300. | |  |  |  |  |
| East Lansing, MI 48823 | |  |  | |  | |  | |  |  |  |
| **Patient**  **Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | | | Account #: | |  | |  | DOB: |  |  |
|  | | | | Home Phone: | |  | |  | Gender: |  |  |
|  | |  | | Account Category: | |  | |  | Age: |  |  |
|  | |  | | ***Social Security #:*** | | \_\_\_\_-\_\_\_-\_\_\_\_ | |  |  |  |  |
| Primary Provider: |  | | |  | |  | |  |  |  |  |
| Referring Provider: |  | | |  | |  | |  |  |  |  |

**Ethnic Group:**  Not Hispanic or Latino  Hispanic or Latino  Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_  Decline to answer

**Race:**  American Indian or Alaskan Native  Asian  Black or African American  White

Hawaiian or Pacific Islander  Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Decline to answer

**Preferred Language:**  English  Spanish  Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Patient Contact Information:** Home: Work: Cell:

Email address:

**Emergency Contact:** Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_

**How would you prefer to be contacted:**  Phone  Mail  Portal Email

**How would you prefer to receive reminders from our office?**  Home Phone  Cell Phone  Work Phone

**Preferred Pharmacy:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Location:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Pharmacy Phone:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

MAIL ORDER PHARMACY: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**HIPAA Consent for Use and Disclosure of Your Health Information**

By specifying and signing below, you are authorizing Lansing Podiatry, and its staff to leave a message on an answering machine, voicemail or with a specified individual, which may include sensitive and/or protected health information.

I **Do\_\_\_\_ Do not\_\_\_\_** authorize Lansing Podiatry, to leave detailed messages regarding my medical condition or treatment on my voicemail.

\_\_\_\_\_ **Release my medical information to myself ONLY.**

\_\_\_\_\_\_\_\_\_

**Initial**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_

**Patient** **Signature** **Date**

**PRINT FULL NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

IF PATIENT IS A MINOR- SIGNATURE OF PARENT/LEGAL GUARDIAN: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Insurance Authorization**

* I authorize the release of any medical information necessary to process my claim and collect payment.
* I authorize payment of medical benefits to Lansing Podiatry, for services rendered when they request that payment be made directly to them.
* I understand that I am ultimately responsible for payment of services that are rendered to me.
* I understand that Lansing Podiatry, will bill my insurance company, however I am responsible for any balance that my insurance does not pay.
* I acknowledge that I am responsible for all copayments and/or deductibles.
* I am aware I am responsible for all costs associated with collection agency fees, attorney fees, and court costs associated with the collection of my debt if applicable.

\_\_\_\_\_\_\_\_\_

**Initial**

**Physician Consent for Medical Treatment**

I, the undersigned, hereby authorize and direct Dr. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_to treat my condition.

I hereby voluntarily consent for care encompassing diagnostic procedures and treatment by my physician, his assistant, designees or consultants, as may be necessary in the judgment of my physician. I am aware that the practice of medicine is not an exact science, and I acknowledge that no guarantees have been made as to the results of the treatments or examination in this clinic. I understand that my medical record may be maintained and authorize access to persons involved in my care.

\_\_\_\_\_\_\_\_\_

**Initial**

**HIPAA Acknowledgement of Receipt of Notification of Privacy Practices**

I have been made aware of the Lansing Podiatry Notice of Privacy Practices. The notice is posted in the waiting area of the Lansing Podiatry office. By signing below, I acknowledge that I have been offered this notice, offered a chance to read this notice, and am aware that I can request a copy of this notice to take with me if so desired.

\_\_\_\_\_\_\_\_\_

**Initial**

**HIPAA Authorization for release of Protected Health Information**

If you choose to have your Protected Health Information released to another person, either verbally or in writing, please complete the information below. Initialing the below authorization will not affect your treatment at Lansing Podiatry, PLLC.

I, **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_,** approve Lansing Podiatry, PLLC, to release my health records to the individuals listed below at my request. I understand this authorization is valid for one year from this date and can be revoked or revised at any time with written notice.

**Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Relationship:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Relationship:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Relationship:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

­­­­

**PATIENT HISTORY**

*This is a confidential record and will be kept in your electronic patient chart.*

*Information contained here will not be released to anyone without your authorization to do so.*

**TODAY’S DATE** \_\_\_\_/\_\_\_\_/\_\_\_\_ **DATE OF BIRTH** \_\_\_\_/\_\_\_\_/\_\_\_\_

**PRINT PLEASE LAST NAME** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **FIRST NAME** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **M.I.** \_\_\_\_

**Family Doctor:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***Reason for seeing the physician:*** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***Have you been exposed to or currently have TB (tuberculosis)?***  **Y N**

***Have you received the Pneumonia Vaccine in the last 9 years?* Y NDate**\_\_\_\_\_\_\_\_\_\_\_\_

**ALLERGIES/REACTIONS TO ANY MEDICATION OR FOOD:**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**LIST CURRENT MEDICATIONS** *(include over the counter items)*

**MEDICATION/DOSAGE**

1.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

4.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

5.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PAST SURGICAL HISTORY – Check previous surgeries & provide date** *(If nothing marked then NONE APPLY)*

\_\_\_\_Appendectomy \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_ Back Surgery \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_Bladder Surgery \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_ Breast Surgery \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_Cesarean Section \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_Cholecystectomy \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_Colon Surgery \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_Coronary Artery Bypass \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_Coronary Stent \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_Cystectomy \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_Cystoscopy \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_Gastric Bypass \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_Green Light PVP \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_Heart Valve Replacement \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_Hernia Repair \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_Hip Replacement \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_Hydrocele Repair \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_Hysterectomy \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_Kidney Stone Removal \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_Knee Replacement \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_Laparoscopy \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_Lithotripsy \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_Mastectomy \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_Nephrectomy \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_Pacemaker Insertion \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PAST MEDICAL HISTORY – Check any previous past medical problems** *(If nothing marked then NONE APPLY)*

\_\_\_\_Anemia

\_\_\_\_Angina

\_\_\_\_Arthritis

\_\_\_\_Asthma

\_\_\_\_BPH

\_\_\_\_Cancer \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List type of cancer

\_\_\_\_Cerebrovascular Accident

\_\_\_\_Chronic UTIs

\_\_\_\_Congestive Heart Failure

\_\_\_\_COPD

\_\_\_\_Coronary Artery Disease

\_\_\_\_Depression

\_\_\_\_Diabetes 1 OR 2

(circle one)

\_\_\_\_Diverticular Disease

\_\_\_\_GERD

\_\_\_\_Gout

\_\_\_\_Hepatitis C

\_\_\_\_Hypercholesterolemia

\_\_\_\_Hyperlipidemia

\_\_\_\_Hypertension

\_\_\_\_Hypothyroid

\_\_\_\_Liver Disease

\_\_\_\_Lupus

\_\_\_\_Migraine Headaches

\_\_\_\_Multiple Sclerosis

\_\_\_\_Myocardial Infarction

\_\_\_\_Osteoarthritis

\_\_\_\_Osteoporosis

(\_\_\_\_Hemo \_\_\_\_Peritoneal)

\_\_\_\_Rheumatoid Arthritis

\_\_\_\_Seizure Disorder

Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**FAMILY HISTORY** ***Indicate*** *what family member has the condition (****FATH, MOTH, SIS, BRO, DAU, SON****)*

Anesthesia Problems\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Kidney Stones\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Lung Problems\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Diabetes\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Heart Problems\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

High Blood Pressure\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Kidney Disease\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Stroke\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Bleeding Disorders\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cancer\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**SOCIAL HISTORY: Please Circle Answers**

**Marital Status:** Married Single Divorced Widowed Legally Separated Annulled Life Partner Unknown

**Smoking Status: (please circle and answer as appropriate)**

Current Every Day Smoker: When did you start smoking? \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Packs smoked per day? \_\_\_\_\_\_\_\_\_\_\_\_\_

Current Some Day Smoker: When did you start smoking? \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Packs smoked per day? \_\_\_\_\_\_\_\_\_\_\_\_\_

Former Smoker: When did you quit? \_\_\_\_\_\_\_\_ Packs smoked per day \_\_\_\_\_\_\_\_ How long did you smoke? \_\_\_\_\_\_\_\_

Never Smoked Smoker, current status unknown Unknown if ever smoked

**Do you use Smokeless Tobacco? (please circle):** Yes No

**Do you drink Alcohol? (please circle):** Yes: How much do you drink? \_\_\_\_\_\_\_\_\_\_\_\_\_ Not Anymore Never Drank

**Drinking habits?** Social Light Moderate Excessive

**Do you use recreational drugs? (please circle):** Yes No

**REVIEW OF SYSTEMS** *(Please circle any symptoms you are currently experiencing)*

**Constitutional:** Fever Chills Weight Loss

**Eyes:**  Blurry vision Cataracts Glaucoma

**Ears, Nose, Mouth, Throat:** Hearing Loss Nasal Stuffiness Sore Throat

**Cardiovascular:**  Chest Pains Swollen Ankles Irregular Heartbeat

**Respiratory:** Shortness of Breath Wheezing Chronic Cough

**Gastrointestinal:** Abdominal Pain Nausea/Vomiting Change in Bowels

**Genitourinary:**  Incontinence Painful Urination Blood in urine

**Musculoskeletal:** Chronic Back Pain Chronic Neck Pain Sore Muscles

**Integumentary/Skin:** Rash Persistent Itching Skin Cancer History

**Neurological:**  Numbness Tingling Dizziness

**Hematologic/Lymphatic:** Swollen Glands Abnormal Bleeding Transfusion History

**Psychiatric:** Anxiety Depression

**APPROXIMATE HEIGHT:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **WEIGHT:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Have you had your flu shot within the last year ? Yes\_\_\_\_ Month: \_\_\_\_\_\_\_ No\_\_\_\_**

**Oct-March (G8482) Declined or advised: \_\_\_ (G8483)**

**Are you A Diabetic? Yes\_\_\_\_\_\_\_ No\_\_\_\_\_\_\_ IF YES what is your Hemoglobin A1C\_\_\_\_\_**

**When was your last A1C checked\_\_\_\_\_\_\_\_\_\_\_\_\_\_**