TARPLEY FOOT & ANKLE CENTER

Patient Name: _____ Date of Birth:_____

Sex: _____M_____F Social Security #:_____

Address: _____
Street City State Zip

Home#: ___ Work#:_____ Cell #:_____

Email:_____ ** Circle which to use for reminder calls.

Single_____ Married _____ Widowed _____ Divorced _____Separated _____

Occupation: _____ Employer: _____

Emergency Contact: _____ Phone #:_____

Primary Physicians Name:

_____

Physician Contact Number: _____ Date Last Seen: _____

Insurance Information

Primary Insurance Name: _____

Policy Holders Name: _____ Insurance ID #:_____

Patients Relationship to Policy Holder: _____

EXPLANATION OF PAYMENT POLICY & PRIVACY POLICY

I hereby authorize Tarpley Foot & Ankle Center to release medical information pertinent to the filing of insurance claims for me. I authorize my insurance carrier to pay benefits directly to Tarpley Foot & Ankle Center on any unpaid services filed on my behalf. I understand that I AM FINANCIALLY RESPONSIBLE for payment to Tarpley Foot & Ankle Center for charges for the above patient regardless of my insurance coverage. I also understand that Tarpley Foot & Ankle Center is not ultimately responsible for collecting my insurance or negotiating settlements of claims. I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have had the opportunity to read and understand the Notice. I also hereby give Tarpley Foot & Ankle Center permission to diagnose and administer treatment for my foot and/or ankle condition and authorize any release of information obtained in the course of my treatment. **I allow Tarpley Foot & Ankle Center to receive and release my personal and medical information that may be pertaining to my treatment, medical history and also diagnosis.**

Patient's Signature: _____ Date: _____

TARPLEY FOOT & ANKLE CENTER

Patients Name: _____ **Shoe Size:** _____

Chief complaint/reason for your visit: _____

Have you ever been to a Podiatrist before? ____YES ____NO **Last visit:** _____

Name of Podiatrist: _____ **Why:** _____

If you have now or have ever had any of the following conditions, please circle:

Ankle Pain	Athletes Foot	Bunions	Corns/Calluses
Foot/Leg cramps	Heel pain	Warts	Cramps/Numbness
Swelling	Tired Feet	Flat Feet	Ingrown Toenails

Alcohol Intake: _____ **Caffeine Intake**: _____
Smoker: ____ pack(s)/day X ____ years **Previous smoker**: YES NO; How much/long: _____
Height: _____ **Weight**: _____

Athletic activities in which you participate (please list and indicate frequency:_____
_____

Have you had a Flu shot this season? YES NO
Have you had the pneumonia vaccine? YES NO

Medications: List current medications & dosage:
_____
_____
_____

Past Medical History: If you now have or have ever had any of the following conditions, please circle:

Thyroid Problems	Hepatitis	Cancer	Ear Disorders
Multiple Sclerosis	Hearing Loss	Circulation Problems	Eye Disorders
Heart Disease	ADD/ADHD	Heart Burn/Reflux	Lymphedema
Anxiety	Bipolar Disorder	Back Problems	Alcohol/Drug Dependency
Anemia	Currently Pregnant	Depression	High Blood Pressure
Children/Pregnancies	Fibromyalgia	Asthma High	Cholesterol
Gout	Prostate Problems	Breathing Problems	Current Kidney Dialysis
Osteoarthritis	Lupus	Pre Diabetes	Diabetes: Type I or Type II
HIV/AIDS	Osteoporosis	Kidney Problems	Neuropathy
Parkinson's	Alzheimer's/Dementia		Other_____

Allergies: Yes No If yes, please list: _____
_____

TARPLEY FOOT & ANKLE CENTER

Family History: Please circle any medical conditions that run in your family and write which member(s) affected

Diabetes _____ Gout _____ Heart Disease_____ Circulation Problems_____
High Blood Pressure_____ High Cholesterol_____ Other_____

Surgeries: List all surgeries you have had. Begin with the most recent. Please give the year.

_____
_____
_____

If **diabetic**, who handles your diabetes?_____Phone #:_____

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.

_____
Patients Signature Date

_____
Name of Parent/Guardian (Please Print)

TARPLEY FOOT & ANKLE CENTER, INC.

20 Highland Park Drive, Suite 101
Uniontown, PA 15401
(724) 437-3668
Fax (724) 437-6648

CONSENT FOR USE & DISCLOSURE OF PROTECTED HEALTH INFORMATION

By signing below, you consent to the use and disclosure of your protected health information by Arnold L. Tarpley, Jr. DPM, our staff, and our business associates for treatment, payment, and health care operations. You have the right to review our Notice prior to signing the consent. The terms of this notice may change. If the terms change, you may obtain a reviewed Notice simply by calling 724-437-3668 and requesting a copy. We will also post any revised notice at our offices. You have the right to request uses or disclosures of your protected health information, which we are otherwise permitted to make for treatment, payment, and health care operations, although we are not required to agree to these restrictions. However, if we agree to accept the extent that we have taken in reliance on it.

My “protected health information” means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer, or a health care clearinghouse. This protected health information relates to my past, present, and future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me. This information will not be sold to outside entities for marketing purposes.

Please sign below acknowledging receipt of this disclosure:

_____

Patients Signature Date

_____

Name of Parent/Guardian (Please Print)

Names of anyone (family, Doctors) you wish our office to release information to:

1. _____
2. _____
3. _____
4. _____
5. _____