

AUTHORIZATION FOR RELEASE OF INFORMATION

I HEREBY AUTHORIZE CLAY COUNTY PODIATRY, LLC to release information requested by my insurance carrier and/or Workers Compensation carrier. Additionally, I authorize CLAY COUNTY PODIATRY, LLC to release information to any hospital or physician I may be referred to by this health care provider.

Date _____

Signature _____

Relationship to Patient _____

ASSIGNMENT OF BENEFITS

I HEREBY AUTHORIZE assignment and payment directly to CLAY COUNTY PODIATRY, LLC of any major medical benefits and/or Medicare due me. I understand that insurance may not and that Medicare does not pay one hundred percent (100%) of the medical charges.

I HEREBY ACKNOWLEDGE and agree to pay any and all charges that exceed or that are not covered by insurance and/or Medicare, including any deductible, I also acknowledge that I am responsible for reasonable interest, collection fees, attorney fees for the greater of a) forty percent (40%) or b) \$300.00 of the outstanding balance, and/or court costs incurred in connection with any attempt to collect amounts I may owe.

Date _____

Signature _____

CONSENT FOR TREATMENT

I hereby request and voluntary consent to such office care, including routine diagnostic procedures and medical treatment as may be deemed necessary by MIRANDA GOODALE, DPM and/or her designees.

Date _____

Signature _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

By signing this document, I acknowledge that I have been provided a copy of CLAY COUNTY PODIATRY, LLC Notice of Privacy Practices.

Date _____

Signature _____

OFFICE USE ONLY

Date acknowledgment received: _____

-OR-

Reason acknowledgment was not obtained: _____

Patient Name _____

Date of birth _____

MEDICAL HISTORY

Reason for visit _____

Primary Care Physician _____

When was your last Primary Care Physician's office visit? _____

Height _____ Weight _____

1. Do you smoke? YES NO

2. Do you use alcohol? YES NO

How many years? _____ # packs per day _____

3. Do you use illegal drugs? YES NO

4. Has anyone in your family had: diabetes heart disease foot problems

5. Have you had any allergic reactions to the following:

Local anesthetics (eg novocaine)..... YES NO

Penicillin..... YES NO

Sulfa Drugs..... YES NO

Sedatives..... YES NO

Iodine..... YES NO

Aspirin..... YES NO

Latex..... YES NO

Other..... YES NO

Please describe _____

6. Are you currently taking any medications? YES NO

Herbal supplements YES NO

Vitamins YES NO

Please list medications (or provide your list to be copied) _____

7. Please list any surgeries you have had _____

8. Have you ever had any of the following? (check those that apply)

- | | | |
|---|--|--|
| Anemia <input type="checkbox"/> | Heart Murmur <input type="checkbox"/> | Polio <input type="checkbox"/> |
| Anorexia <input type="checkbox"/> | Heart Disease <input type="checkbox"/> | Prostate Problem <input type="checkbox"/> |
| Arthritis <input type="checkbox"/> | Hepatitis - A - B - C <input type="checkbox"/> | Psychiatric Care <input type="checkbox"/> |
| Asthma <input type="checkbox"/> | Hernia <input type="checkbox"/> | Respiratory Disease <input type="checkbox"/> |
| Back Problems <input type="checkbox"/> | Herpes <input type="checkbox"/> | Rheumatoid Arthritis <input type="checkbox"/> |
| Bleeding Tendency <input type="checkbox"/> | High Blood Pressure <input type="checkbox"/> | Rheumatic Fever <input type="checkbox"/> |
| Blood Disease <input type="checkbox"/> | HIV/AIDS <input type="checkbox"/> | Scarlet Fever <input type="checkbox"/> |
| Cancer <input type="checkbox"/> | Jaundice <input type="checkbox"/> | Stroke <input type="checkbox"/> |
| Chemical Dependency <input type="checkbox"/> | Kidney Disease <input type="checkbox"/> | Thyroid Problems <input type="checkbox"/> |
| Chemotherapy <input type="checkbox"/> | Liver Disease <input type="checkbox"/> | Tonsillitis <input type="checkbox"/> |
| Chicken Pox <input type="checkbox"/> | Low Blood Pressure <input type="checkbox"/> | Tuberculosis <input type="checkbox"/> |
| Circulatory Problems <input type="checkbox"/> | Measles <input type="checkbox"/> | Ulcer <input type="checkbox"/> Stomach <input type="checkbox"/> Other <input type="checkbox"/> |
| Congenital Heart Lesions <input type="checkbox"/> | Migraine Headaches <input type="checkbox"/> | Venereal Disease <input type="checkbox"/> |
| COPD <input type="checkbox"/> | Mitral Valve Prolapse <input type="checkbox"/> | Any Other Condition <input type="checkbox"/> |
| Diabetes <input type="checkbox"/> | Mumps <input type="checkbox"/> | Please describe _____ |
| Emphysema <input type="checkbox"/> | Multiple Sclerosis <input type="checkbox"/> | _____ |
| Epilepsy <input type="checkbox"/> | Pacemaker <input type="checkbox"/> | _____ |
| Glaucoma <input type="checkbox"/> | Pneumonia <input type="checkbox"/> | |

9. Have you experienced any of the following in the last month?

- | | | |
|---|---|--|
| <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Nausea/Vomiting | <input type="checkbox"/> Shortness of Breath |
| <input type="checkbox"/> Cough - persistent or bloody | <input type="checkbox"/> New joint pain | <input type="checkbox"/> Sinus Trouble |
| <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Numbness/Tingling <input type="checkbox"/> hands <input type="checkbox"/> feet | <input type="checkbox"/> Skin Rash |
| <input type="checkbox"/> Difficulty/Pain Urinating | <input type="checkbox"/> Persistent Headache | |