HUDSON PODIATRY, LLC
1315 Corporate Dr. Suite B
Hudson, Ohio 44236

Patient Name_____DOB_____

Address_____

City_____State_____Zip_____

E-mail Address _____

Home Phone #_____Cell #_____

Preferred for appt. reminder: ☐ Call ☐ Text Sex____Marital Status S M D W

Employer_____Occupation_____

How did you learn of our practice

Primary Physician_____Phone #_____

Pharmacy_____Phone #_____

Emergency Contact _____Phone #_____

INSURANCE INFORMATION

Primary Insurance_____

Subscriber's name_____DOB_____Sex___Relationship to patient_____

Secondary insurance coverage Yes No

Secondary Insurance_____

Subscriber's name_____DOB_____Sex___Relationship to patient_____

ASSIGNMENT AND RELEASE

The undersigned hereby authorizes the release of any information relating to all claims for benefits submitted on behalf of myself and/or dependents. I further expressly agree and acknowledge that my signature on this document authorizes my physician to submit claims for benefits, for services rendered or for services to be rendered without obtaining by signature on each and every claim to be submitted for myself and or dependents and that I will be bound by this signature as though the undersigned had personally signed the particular claim to pay and hereby assign directly to _____**Ronald Stein D.P.M,**____ all benefits, if any, otherwise payable to me for his/her services as described on the attached forms. I understand I am financially responsible for all charges incurred, I further acknowledge that any insurance benefits, when received by and paid to _____**Ronald Stein**_____ will be credited to my account in accordance with the above said assignment.

CONSENT TO TREAT AND FINACIAL RESPOSIBILTY

I authorize **HUDSON PODIATRY** and any employee working under the direction of my physician to provide medical care for me or the patient I am legally responsible for. This medical care may include services and supplies related to my health (or the identified person) and may include (but not limited to) preventive, diagnostic, therapeutic, rehabilitative, maintenance, palliative care, counseling, assessment or review of physical and mental status/function of the body and the sale or dispensing of drugs, device or other items required in accordance with prescription. This consent includes contact and discussion with other health care professionals for care treatment.

_____ _____

Signature of patient or guardian Date

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Hudson podiatry furnishes a Notice of Privacy Practices, which can be provided upon request, illuminating the use/disclosure of healthcare information.

Statements regarding race, ethnicity and preferred language are deemed personal and not for dissemination, unless otherwise noted.

Contact may be through mail, e-mail, and phone as listed on the encounter form as well as text messaging/voicemail/answering machine unless otherwise declared. Messages may be left with the emergency contact as noted.

Sharing of Advanced Directives with this organization is declined.

Pursuant to the treatment, I consent to a review of my prescription history.

Signature of this form is acknowledgment of its receipt.
This information is exempt from public reporting.

_____

Please print your name

_____

Signature

_____

Date

FOR OFFICE USE ONLY

Written acknowledgement from this patient of receipt of the Notice of Privacy Practices could not be obtained because:

- o The patient refused to sign
- o Communication with the patient was not possible
- o An emergency situation arose
- o Other _____

_____

_____

_____ _____

HUDSON PODIATRY, LLC

Name:_____ DOB:

Your current foot complaint:_____

Is your current foot complaint related to a work injury or auto accident? Yes No

	Yes	No
Have you been ill recently?		
Have you been hospitalized in the past three years?		
In the last year, have you been injured in a fall or fallen more than twice?		
High Cholesterol		
High Blood Pressure		
Diabetes ☐ TYPE I ☐ TYPE II		
Gout		
Lyme Disease		
Liver Disease, Jaundice or Mononucleosis		
Rheumatic Fever; Scarlet Fever; Mitral Valve Prolapse		
Thyroid Condition		
Severe infection or poor wound healing		
Prolonged bleeding problems		
Are you on blood thinners? eg: Aspirin, Coumadin, Pradaxa, Elequis, Xarelto, Plavix or Effient?		
Are you pregnant?		
Do you smoke? ☐ Current smoker ☐ Former smoker ☐ Never smoked		
Do you drink alcohol? ☐ Light ☐ Moderate ☐ Heavy		
Have you ever had any significant medical/surgical condition not noted on this form?		
Please list previous surgeries on the back:		
Please list current medications on the back		
Please list allergies to any pills or medication:		
Are you allergic to latex, iodine, shellfish or any other foods?		
Relevant family medical history?		

Review of Systems (Please check the box if you currently have any of these symptoms/conditions or check "NONE"

Cardiovascular	☐ Leg pain when walking ☐ Leg swelling	☐ Fainting ☐ Fever ☐ Palpitations	☐ Chest pain/ pressure ☐ Vascular disease	☐ Valve problems ☐ Cold hands/feet	☐ **NONE**
Genitourinary	☐ Blood in urine ☐ Incontinence	☐ Hesitancy ☐ Excessive urination	☐ Decreased frequency ☐ Increased urgency	☐ Kidney stones ☐ Kidney disease	☐ **NONE**
Gastrointestinal	☐ Abdominal pain ☐ Diarrhea ☐ Constipation	☐ Heartburn ☐ Trouble swallowing	☐ Blood in stool ☐ Decrease appetite ☐ Increase appetite	☐ Vomiting ☐ Ulcers	☐ **NONE**
Integumentary	☐ Athletes foot	☐ Nail abnormalities	☐ Keloids (scars)	☐ Itchiness ☐ Dry, scaly skin	☐ **NONE**
Hematological	☐ Lower leg ulcers	☐ Sickle cell disease	☐ Anemia	☐ Blood thinners ☐ Clotting disorder	☐ **NONE**
Neurological	☐ Tingling ☐ Numbness	☐ Weakness ☐ Paralysis	☐ Seizures ☐ Tremors	☐ Headaches	☐ **NONE**
Musculoskeletal	☐ Neck pain ☐ Back pain ☐ Sciatica	☐ Joint pain ☐ Joint stiffness ☐ Joint swelling	☐ Joint instability ☐ Muscle weakness ☐ Muscle pain	☐ Arthritis	☐ **NONE**
Respiratory	☐ Chest pain ☐ Shortness of breath	☐ Wheezing ☐ Emphysema	☐ COPD ☐ TB ☐ Asthma	☐ Coughing ☐ Snoring	☐ **NONE**

Signature of patient or guardian _____

Date _____