



Date: \_\_\_\_\_

James A. Anderson, Jr. & Associates Podiatric Physicians

**Patient Information**

Name: \_\_\_\_\_ Birthdate: \_\_\_\_\_ Age: \_\_\_\_\_

Address: \_\_\_\_\_ Marital Status: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Spouse's Name: \_\_\_\_\_

Patient SS#: \_\_\_\_\_ Email: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell: \_\_\_\_\_

In case of emergency contact: Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Home: \_\_\_\_\_ Work: \_\_\_\_\_ Cell: \_\_\_\_\_

Who may we thank for referring you to our office: \_\_\_\_\_

**Primary Care Physician:** \_\_\_\_\_ **When was your last visit:** \_\_\_\_\_

**Pharmacy:** \_\_\_\_\_ **Location:** \_\_\_\_\_

**Reason for Visit:** *(Describe foot problems and concerns)* \_\_\_\_\_

**When Did Problem Start?** \_\_\_\_\_ **How long have you had your current symptoms?** \_\_\_\_\_

**Have your symptoms increased, decreased or remained the same since they began?** \_\_\_\_\_

**Medical History:** *(check if you had or have any of the following)*

\_\_\_ Diabetes    \_\_\_ Type I    \_\_\_ Type II    \_\_\_ Controlled    \_\_\_ Uncontrolled

\_\_\_ Hypertension *(High blood pressure)*    \_\_\_ Tuberculosis    \_\_\_ Asthma    \_\_\_ Kidney Disease

\_\_\_ Bleeding/Clotting Disorders    \_\_\_ Rheumatic Fever    \_\_\_ Anemia    \_\_\_ Gout

\_\_\_ PVD *(Circulation Disease)*    \_\_\_ Arthritis    \_\_\_ Cancer    \_\_\_ Epilepsy

\_\_\_ Hepatitis *(Liver Disease)*    \_\_\_ Stomach Ulcers    \_\_\_ Cramps or numbness in feet or legs

\_\_\_ Heart Disease    Other(s) \_\_\_\_\_

\_\_\_ High Cholesterol \_\_\_\_\_

**Past Surgical History:** *(Please include date of surgery)*

**Social History:** Smoking (packs/day x years) \_\_\_\_\_ Alcohol \_\_\_\_\_

Recreational Drugs \_\_\_\_\_ Other(s) \_\_\_\_\_

**Family History:** Diabetes \_\_\_\_\_ Heart Disease \_\_\_\_\_ Cancer \_\_\_\_\_ Hypertension \_\_\_\_\_

Anemia \_\_\_\_\_ Stroke \_\_\_\_\_ Other \_\_\_\_\_

**Medications:** *(Including Non-Prescription and Herbal Medications)*

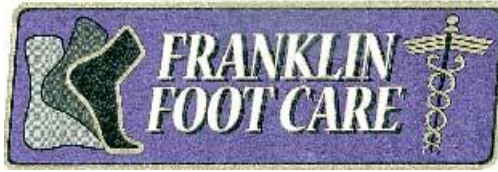
**Allergies:** *Please list any allergies:*

\_\_\_ None    \_\_\_ Penicillin    \_\_\_ Sulfa    \_\_\_ Egg    \_\_\_ Latex

\_\_\_ Local Anesthetic    \_\_\_ Aspirin    \_\_\_ Codeine    \_\_\_ Tape

\_\_\_ Iodine    \_\_\_ IV Dye

\_\_\_ Other(s) \_\_\_\_\_



Dr. James Anderson Dr. Sherry Hicks Dr. Brooke Keeley Dr. Damien Lucius Dr. Shane Stenehjem

**Notice of Privacy Practices**

This note describes how medical information about you can be used and how you can get access to this information. Please read carefully.

Your medical record is protected under HIPAA federal law. There are limitations upon to whom and under what circumstances your medical information can be disclosed. **We do not share your private medical information with anyone including your spouse, parent or employer unless you request it or unless required by law.**

The law allows us to share your medical information with your insurance company in order to verify eligibility and that payment is appropriated for the visit. They may also review your record to ensure that we meet quality standards. We share information with other providers who are treating you or who referred you to us for consultation or treatment. We also provide information about your care and diagnosis when we request tests at the hospital or labs, such as x-ray or laboratory testing. These other providers are also required to protect the confidentiality of your health information under HIPAA.

We may consult you by mail or leave a general message by phone, but we will not give your test results or other private information to a family member without your permission.

We are not affiliated with any drug companies or other marketing services and will not release your health information to anyone for the purpose of marketing services to you. We may, however, give you a reminder by phone of an upcoming appointment. We may disclose information to the FDA in the event of an adverse drug reaction, as required by law, to the Dept. of Public Health in the event of certain communicable diseases.

You may review your medical records or obtain a copy of them upon request. There is a charge for copying depending on the number of pages involved. HIPAA also allows you to make additions or corrections to your medical records. If you have questions about our policy of protecting your private medical record, you may discuss them with our office manager.

\*\*Signature \_\_\_\_\_ Date \_\_\_\_\_

I have read the above Privacy Practices

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**Permission to treat**

I hereby give permission to Franklin Foot Care to examine and/or administer treatment as necessary in the diagnosis & treatment of my foot problem(s). I certify that I and/or my dependents have insurance coverage or will pay privately & assign directly to Franklin Foot Care all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by my insurance.

\*\*Signature: \_\_\_\_\_ Date: \_\_\_\_\_

If signed by a parent/guardian, state relationship to patient: \_\_\_\_\_

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**Cancellation Policy**

I understand the office requires 24 hours notice for appointment cancellations. If 24 hours notice is not provided, I understand I may be charged a \$25 No-Show/Cancellation Fee.

\*\*Signature: \_\_\_\_\_ Date: \_\_\_\_\_