

Account # _____
Resp. Party # _____

Associated Foot Surgeons
STEVEN J. WATSON, D.P.M.
WILLIAM H. DABDOUB, D.P.M.

F/C _____
DR. _____ LOC _____

PATIENT INFORMATION

Patient: Last MI First
Mailing Address: _____
Hm. Ph: _____ Wk. Ph: _____ Ext. _____
Social Security # _____
Employer: _____
Referred by _____
Date of Injury _____

Title: Mr./Mrs./Other: _____ Suffix: Jr./Sr./Other: _____
City State Zip
Date of Birth: _____ Sex: M or F
Marital Status: Married Single Widowed Divorced (circle one)
Student: Full Part-Time (circle one)
Employment Status: Full time Self-employed
Part time Not Employed Unknown
Retired Military Service
Is the injury work related? _____

II. RESPONSIBLE PARTY INFORMATION

SEND STATEMENT TO

Patient: Last MI First
Mailing Address: _____
Hm. Ph: _____ Wk. Ph: _____ Ext. _____
Social Security # _____
Employer: _____

Title: Mr./Mrs./Other: _____ Suffix: Jr./Sr./Other: _____
City State Zip
Date of Birth: _____ Sex: M or F
Employment Status: Full time Self-employed
Part time Not Employed Unknown
(circle one) Retired Military Service

III. PRIMARY INSURANCE INFORMATION

Insurance Company: _____
Address: _____
City State Zip
Patient's Relationship to Insured: Self Child Male Other
Group # _____ Policy # _____
CoPay: Primary Care _____ Specialist: _____
Insured's Name: Last MI First

Insurance Company: _____
Address: _____
City State Zip
Patient's Relationship to Insured: Self Child Male Other
Group # _____ Policy # _____
CoPay: Primary Care _____ Specialist: _____
Insured's Name: Last MI First

IV. INSURED INFORMATION
INSURANCE POLICY HOLDER

Address: _____
City State Zip
Hm. Ph: _____ Wk. Ph: _____ Ext. _____
Date of Birth: _____ Sex: M or F
Employer: _____ Status: _____

Address: _____
City State Zip
Hm. Ph: _____ Wk. Ph: _____ Ext. _____
Date of Birth: _____ Sex: M or F
Employer: _____ Status: _____

I hereby authorize the above listed insurance company(s) to pay directly to Associated Foot Surgeons benefits due me, if any, as provided in the above unexpired policy. I will pay all charges in excess of whatever sums may be allowed by my insurance, and acknowledge amounts due from the outstanding greater than 30 days will be assessed a finance charge of 1 1/2 % per month. I hereby authorize Associated Foot Surgeons to release information to the insurance company for my claims to be paid. A copy of my insurance card is attached.

Signature

Date

I acknowledge that I was provided a copy of the Notice of Privacy Practices to read, if I so chose, and understood the notice.

Signature

Date

MEDICAL INFORMATION

This information is important for our records and your health.

Describe your foot problem:

How long has it been bothering you? _____ Days _____ Weeks _____ Years

Any past problems of your feet and ankles? _____

Any past surgical procedures on your feet and ankles? _____

Shoe Size _____ Current Weight: _____ Height: _____

Are you allergic or sensitive to:

Antibiotics (Penicillin, Sulfa drugs, etc.)? _____

Any Medicines: _____

Tape? _____ Betadine (iodine)? _____ Other: _____

Have you had any problems taking aspirin or Ibuprofen (Advil, Motrin)? Yes No

Any problem with local anesthetics (Novocaine, Lidocaine)? Yes No

GENERAL HEALTH INFORMATION

Do you have diabetes? Yes No If yes, do you take insulin? Yes No

Do you have HIV? Yes No Do you have hepatitis? Yes No

Have you had any serious illnesses? _____

Have you had any major surgeries? _____

Are you under a physician's care? Yes No If yes, for what condition? _____

Family Physician: _____ Date you last saw this doctor: _____

May we contact your physician about your health? Yes No

Name of your pharmacy or drug store: _____ Phone #: _____

What medications do you take regularly? _____

Check (✓) any of the following you have or have had a problem with:

- () Heart () Asthma () _____ () Unexplained weight loss
- () Circulation () Stomach Ulcers () Gout () Frequent infections
- () Arthritis () Hormones () Tuberculosis () Healing
- () Kidneys () Anemia () Rheumatic Fever () Neurological Disorder
- () Lungs () Bladder () Liver () Intestines
- () Cancer () High Blood Pressure

Do you have any artificial joints:

- Hip Yes No
- Knee Yes No

Other: _____

Do you have a heart valve implant: Yes No

FAMILY HISTORY

Mother:	Living: _____	Deceased: _____	Cause of Death: _____
Father:	Living: _____	Deceased: _____	Cause of Death: _____
Brother:	Living: _____	Deceased: _____	Cause of Death: _____
Sister:	Living: _____	Deceased: _____	Cause of Death: _____

Is there a family (close relative) history of:

- () Heart Disease
- () Bleeding Disorder
- () Neurological Disorder
- () Stroke
- () Bunions
- () Hammertoes
- () Flat feet
- () Circulation problems in legs or feet

Do you smoke? No Yes # packs/day: _____

Did you previously smoke? No Yes # years: _____ # packs/day: _____

Do you drink alcohol or beer? No Yes
() Light usage (1-2/week) () Moderate (1-2/day) () Heavy (more than 2 a day)

Employment: () Sits at job () Stands at job () Stands and walks at job () Retired

Signature: _____ Date: _____

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WILLIAM H. DABDOUB, D.P.M.

**New Patient Consent to the Use and Disclosure of Health Information
for Treatment, Payment, or Healthcare Operations**

I, _____, understand that as part of my healthcare, Associated Foot Surgeons originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment;
- A means of communication among the many health professionals who contribute to my care;
- A source of information for applying my diagnosis and surgical information to my bill;
- A means by which a third-party payor can verify that services billed were actually provided; and
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professions.

I understand that I have the following rights and privileges under the federal regulations:

- The right to review the notice prior to signing this consent;
- The right to object to the use of my health information for direct purposes; and
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations.

I understand that Associated Foot Surgeons is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon. I also understand that by refusing to sign this consent, or by revoking this consent, Associated Foot Surgeons may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

I further understand that Associated Foot Surgeons reserves the right to change its notice and practices, prior to implementation in accordance with Section 164.506 of the Code of Federal Regulations. Should Associated Foot Surgeons change its notice, it will send a copy of any revised notice to the address I have provided (whether U.S. mail or, if I agree, e-mail).

I wish to have the following restrictions to the use or disclosure of my health information:

I understand that as part of Associated Foot Surgeons' treatment, payment, or healthcare operations, it may become necessary to disclose my protected health information to another entity and I consent to such disclosure for these permitted uses, including disclosures, via fax.

I fully understand and accept / decline the terms of this consent.

Patient's Signature

Date

I acknowledge that I was provided a copy of the Notice of Privacy Practices to read, if I so chose, and understood the notice.

Signature

Date

**Associated Foot Surgeons
STEVEN J. WATSON, D.P.M.
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SPOUSAL TELEPHONE, MAIL, E-MAIL CONSENT FORM

I hereby authorize my physician to release medical information obtained in the course of my medical examination or treatment to my spouse.

Patient Name (please print)

Date of Birth

Patient Signature

Date

If information is to be released to party other than spouse, please indicate.

I consent to my physician or Associated Foot Surgeons to contact me by mail, via telephone (including voice mail), or by e-mail, in regard to healthcare information and treatment plans.

Patient Signature

Date

Patient's E-mail Address

Patient's Phone Number

Witness Signature

Date