HEEL & TOE PODIATRY

R. Scott Johnston, D.P.M

General Podiatry, Podiatric Surgery, Home Care, Nursing Home

New Patient Information

Name: _____ Birthday: ____/____/_____ Todays Date: ____/____/_____

Address: _____ City: _____ State:____ Zip: _____

Cell Phone: (___)-____-_____ Home Phone: (___)-____-_____Email: _____

SSN: ____-___-_____ Gender: ☐ M ☐ F Marital Status: _____

Age: ____ Height: ____ Weight: _____ Shoe Size: _____

Employer/School: _____ Occupation: _____

Employer Address: _____ Employer Phone: (___)-____-_____

Emergency Contact: _____ Emergency Contact Phone: (___)-____-_____

How did you Hear About Us? ☐ Former Patient ☐ Friends ☐ Family ☐ Referral from _____

Preferred Pharmacy:_____ Location: _____

Primary Care Physician: _____ Last Visit: ____/____/_____

Location: _____ Phone: (___)-____-_____

Insurance Information

Primary Insurance Company: _____

Who is responsible for this account: _____ Relationship to Patient_____

Insured DOB: ____/____/_____ Insured SSN: ____-___-_____ Employer: _____

Account Number: _____ Group Number: _____

Secondary Insurance Company: _____

Who is responsible for this account: _____ Relationship to Patient_____

Insured DOB: ____/____/_____ Insured SSN: ____-___-_____ Employer: _____

Account Number: _____ Group Number: _____

email: HeelandToePodiatry@gmail.com phone: 419.474.7700 fax: 419.474.0896

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Authorizations

Insurance Assignment and Release
I certify that I have insurance with the above company and assign directly to Dr. Johnston/Heel and Toe Podiatry all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether paid by insurance or not. I authorize the use of my signature on all insurance submissions. Dr. Johnston, and Heel and Toe Podiatry may use my health care information and may disclose such information to the above-named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. In addition, I agree that my information can be used for collection purposes should I refuse to pay for services received in accordance to clinic financial policies.

Medicare/Medigap
I request that payment of authorized Medicare benefits and, if applicable, Medigap benefits, be made on my behalf to Dr. Johnston/Heel and Toe Podiatry for any services provided to me. To the extent permitted by law, I authorize any holder of medical or other information about me to release to the Centers for Medicare and Medicaid Services, my Medigap insurer, and their agents any information needed to determine these benefits or benefits for related services.

Missed Appointment Policy: I understand that a $25 fee is charged for missed appointments or appointments not rescheduled within 24 hours. This fee must be paid before an appointment is rescheduled. After 3 missed appointments, I will no longer be allowed to schedule.

Non-Solicitation: I have found Robert Scott Johnston DPM and Heel and Toe Podiatry on my own. I was not solicited in any form at, any time by Dr. Robert Scott Johnston or Heel and Toe Podiatry.

_____
Printed Name

_____ _____
Signature of Patient or Guardian Date

_____
Relationship to Patient

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Presenting complaint(s)

What Is the main Problem/Concern with your Feet? _____

When did it start? _____. How did it Start? _____

Did it happen at work? ☐ Y ☐ N Are you Claiming Workers Comp? ☐ Y ☐ N

What Does it Feel Like: Painful, burning, tingling, Pins & Needles, Radiating, Shooting, Aching, Dull, Throbbing, Sharp, Stabbing, Numbness

When is pain present: constantly, intermittent, comes and goes, random, with walking, with standing, with working, with sports, with activity, with shoes, without shoes, in AM, in PM, at rest, in bed

What have you tried so far? _____

Have you been treated by another Foot Doctor/podiatrist? ☐ Y ☐ N if so, Who_____

How severe is your pain? On a scale of 1-10 where 1 equals Mild pain. And 10 equals the most severe Pain. Rate your pain: Please Circle: **1 2 3 4 5 6 7 8 9 10**

Past Medical History

* Please check or circle any of the following conditions that you have or have had in the past

☐ AIDs/HIV ☐ Anemia ☐ Angina ☐Arthritis Osteo ☐ Arthritis Rheumatoid ☐ Arthritis Psoriatic ☐ Back Problems. ☐ Bleeding Disorders ☐ Blood Clots ☐ Bursitis ☐ Cancer ☐ Chemical Dependency ☐ Chemotherapy ☐ Chest Pain ☐ Circulatory Problems ☐ Colitis / Crohn's ☐ COPD ☐ Diabetes ☐ Epilepsy ☐ Eye Problems ☐ Fibromyalgia ☐ Foot/Leg Cramps ☐ Glaucoma ☐ Gout ☐Headaches/Migraines ☐ Heart disease ☐ Heartburn/GERD/Reflux ☐ Hepatitis ☐ High Blood Pressure ☐ High Cholesterol ☐ Impaired Memory ☐ Joint Implants ☐ Kidney Problems ☐ Liver Disease ☐ Low Blood Pressure ☐ Lung Disease ☐ Neuropathy ☐ Osteoporosis/osteopenia ☐ Phlebitis. ☐ Psychiatric problems. ☐ Radiation Therapy ☐ Rheumatic Fever ☐ Stroke ☐ Sickle Cell ☐ STD ☐ Stomach Ulcers ☐ Skin Disorders. ☐ Skin Ulcerations ☐☐ Tumors ☐ Tuberculosis ☐ Thyroid Disease ☐ Swelling/Edema ☐ Varicose Veins

Diabetes: Todays Blood Sugar: _____ Most Recent A1c Date: _____/____/_____ A1c Result: _____

Doctor Treating your Diabetes: _____ Last Visit _____/____/_____

Are You Pregnant? ☐ Y ☐ N How many months? _____

Have you been Hospitalized? ☐ Y ☐ N if so, When and what for_____

Past Surgeries
When: _____/____/_____ What was done?
When: _____/____/_____ What was done?
When: _____/____/_____ What was done?

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Allergies:

☐ None ☐ Penicillin ☐ Sulfa ☐ Iodine ☐ Ciprofloxacin. ☐ Clindamycin ☐ Tetracycline ☐ Latex ☐ Cobalt ☐ Chromium ☐ Stainless Steel ☐ Other Metals ☐ Codeine ☐ Percocet ☐ Vicodin ☐ Demerol ☐ Darvocet ☐ Aspirin ☐ NSAIDs

Other:_____

Medications

Medication and Dose	Medication and Dose

Family History

Mother: ☐ Diabetes ☐ Heart Disease ☐ High Blood Pressure ☐ Arthritis. ☐ Gout. ☐ Thyroid. ☐ Cancer ☐ Foot Problems _____

Father: ☐ Diabetes ☐ Heart Disease ☐ High Blood Pressure ☐ Arthritis. ☐ Gout. ☐ Thyroid. ☐ Cancer ☐ Foot Problems _____

Social History

Do you Smoke Tobacco? ☐ Y ☐ N # Packs per day_____ How long have you Smoked? _____

Former Smoker? ☐ Y ☐ N When did you quit? _____ How many years did you smoke? _____

Do you Drink Alcohol? ☐ Y ☐ N If yes, How much? ☐ < 1/week ☐ 1-2/week ☐ 1-2/day ☐ >3/day.

Do you utilize any Recreational Drugs? ☐ Y ☐ N ☐ Marijuana. ☐ Cocaine ☐ Heroin ☐ Others_____

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Acknowledgement of Receipt of Notice of Privacy Practices

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read if I so choose) and understood the notice.

_____ _____

Patient Name (Please Print) Date

_____

Parent or Authorized Representative (if applicable)

_____

Signature

Electronic Access to Your Health Information

Part of your rights as a patient is to receive all your health documents on a timely basis as well as electronically. Heel and Toe Podiatry asks for your email address to send you your visit notes, educational resources, as well as any other important health notices in a secure manner. Please provide an updated email below and all your health records will be sent to you electronically through a national healthcare site known as Health Vault using the email you provide.

I **DECLINE** electronic communication at this time: _____

Signature

I **ACCEPT** Electronic Communication

Patient email: _____

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Summary of Notice of Privacy Practices

This summary is provided to assist you in understanding our

Notice of Privacy Practices, which is available upon request

The available Notice of Privacy Practices contains a detailed description of how out office will protect your health information, your rights as a patient and our common practices in dealing with patient health information. Please refer to that Notice for further information.

Uses and Disclosures of Health Information. We will use and disclose your health information in order to treat you or to assist other healthcare providers in treating you. We will also use and disclose your health information in order to obtain payment for our services or to allow insurance companies to process insurance claims for services rendered to you by us or other healthcare providers. Finally, we may disclose your health information for certain limited operational activities such as quality assessment, accreditation, and training of students.

Uses and Disclosures Based on Your Authorization. Except as stated in more detail in the available Notice of Privacy Practices, we will not use or disclose your health information without your written authorization.

Uses and Disclosures Not Requiring Your Authorization. In the following circumstances, we disclose your health information without your written authorization:

- To family members or close friends who are involved in your healthcare
- For certain limited research purposes
- For purposes of public health and safety
- To Governmental agencies for purposes of their audits, investigations, and other oversight activities
- To government authorities to prevent child abuse or domestic violence
- To the FDA to report product defects or incidents
- To law enforcement authorities to protect public safety or to assist in apprehending criminal offenders
- When required by court orders, search warrants, subpoenas and as otherwise required by the law.

Patient Rights. As our patient, you have the following rights:

- To have access and/or a copy of your health information
- To receive an accounting of certain disclosures we have made of your health information
- To request restrictions as to how your health information is used or disclosed
- To request that we communication with you in confidence
- To request that we amend your health information
- To receive notice of our privacy practices.

If you have question, concern, or complaint regarding our privacy practices, please refer to the available Notice of Privacy Practices for the person or persons whom you may contact.

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