Welcome to Affiliated Fan Podiatry!

Patient Registration

Patient's name:		
Street address:		
PO Box/Apt:		
City:	State:	ZIP:
Home phone: ( )	Work phone: ( )	
Cell phone: ( )	SSN:	
Gender:	Date of birth:	
E-mail address:		
How did you hear about our office?		
Patient's primary care physician:		
Date of last physical:		
Pharmacy (+location or phone):		
Marital status:		
Employer/Occupation:		
Emergency contact:		
Street address:		
City:	State:	ZIP:
Telephone: ( )	Relationship to patient:	
The person responsible for the patient's bill:		
Street address:		
City:	State:	ZIP:
Home phone: ( )	Work phone: ( )	
Policyholder's name (if not the patient):		
Date of birth:	Relationship to patient:	

Consent to Medical Care

I. Dr Duke has my permission to treat my (the Patient's) foot problem.

II. In accordance with the *Notice of Privacy Practices*, I authorize Dr Duke to disclose my medical records as necessary to obtain payment from my insurance company or other third-party payer. I authorize the payment of medical benefits to Affiliated Fan Podiatry. I accept financial responsibility for any claim denied for want of a referral.

III. Routine Foot Care: Health plans generally do not cover such foot care as cutting toenails or trimming calluses. I accept financial responsibility for such non-covered foot care.

Signature:_____ Date:_____

PRIVACY CONSENT FORM (*required)*

I understand that under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

Conduct, plan, and direct my treatment and follow-up care among multiple healthcare providers who may be involved in that treatment directly and indirectly;

Obtain payment from third-party payers;

Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been informed by you of your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such *Notice of Privacy Practices* prior to signing this consent. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address below to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is disclosed to carry out treatment, payment, or other health care operations. I also understand you are not required to agree to my requested restrictions, but that if you do agree, then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time except to the extent that you have taken action relying on this consent.

Signature:	Date:
Relationship to Patient:	

Yearly Renewal of Consent

Signature:	Date:
Signature:	Date:
Signature:	Date:
Signature:	Date:
Signature:	Date:

Consent to Retrieve Medication History

So that Dr Duke may better provide podiatric care, I authorize him to communicate with my other healthcare providers or my insurance carrier to obtain my recent medication history. Such history may include details about the name, strength, dosage, dispensing, available refills, and reaction to any prescription medication I have been given within the past twenty-four months. This information shall be used only for my care, to coordinate with my other healthcare providers, or to fulfill requirements of the law.

IF I DECLINE to give Dr Duke this authorization, I understand that I may be limiting my treatment options or may be exposing myself to a higher risk of such adverse drug interactions as overmedication, stroke, seizures, or organ damage. I also understand that Dr Duke is authorized by law to use the resources of the Virginia Prescription Monitoring Program to prevent the abuse or diversion of controlled substances.

Signature:	Date:
Relationship to Patient:	

Consent to Exchange Health Information

To provide for better medical treatment and to reduce duplicate services, I authorize any of my physicians or other healthcare providers to send Dr Howard F Duke medical records or the results of any medical test from the previous twenty-four months which may be appropriate for my podiatric care. Some examples of such tests would be radiology reports, neurology reports, blood or urine analyses, allergy tests, tissue pathologies, or culture tests for infection. These examples are not exhaustive. I authorize my physicians or other healthcare providers to use their medical judgement or to consult with Dr Duke about the propriety of sending such information.

I likewise authorize Dr Duke to send to my physicians or other healthcare providers medical records or the results of any medical test he may perform which may be appropriate for my medical care.

Unless urgently necessary for my welfare, such highly personal information as my mental or behavioral health should not be sent without my specific consent. My providers may, however, review my podiatric care with Dr Duke and note potential complications or contraindications.

Signature:	Date:
Relationship to Patient:	

Yearly Renewal of Consent

Signature:	Date:
Signature:	Date:
Signature:	Date:
Signature:	Date:
Signature:	Date:

Race:	Ethnicity:
Primary language:	
Healthcare providers have been directed by the US Department of Health and Human Services to request patients' racial and ethnic class as defined by the White House Office of Management and Budget. According to the OMB, these classifications are social-political constructs and not scientific or anthropological in nature. As such, they are not meaningful to your podiatric care. You may refuse to answer ❑	

Height:	Weight:	Shoe size:
How physically active are you?		
What foot problems concern you?		

Normally, can you walk half a mile? ..... ❑ Yes ❑ No
Normally, can you walk one mile? ..... ❑ Yes ❑ No
Do you get leg cramps when you walk? ..... ❑ Yes ❑ No
Are your feet cold to touch? ..... ❑ Yes ❑ No
Do your feet change colors? ..... ❑ Yes ❑ No
Do you use tobacco? ..... ❑ Yes ❑ No
Do you drink alcohol? ..... ❑ Yes ❑ No

Please mark if you have any history of the following:

Condition	***Patient's history***	***Details/Family history***
Arthritis	❑ Yes ❑ No	
Bleeding or bruising easily	❑ Yes ❑ No	
Blood disorder	❑ Yes ❑ No	
Cancer	❑ Yes ❑ No	
Circulatory disease	❑ Yes ❑ No	
Diabetes	❑ Yes ❑ No	
Heart disease	❑ Yes ❑ No	
High blood pressure	❑ Yes ❑ No	
Joint replacement of hip	❑ Yes ❑ No	
Joint replacement of knee	❑ Yes ❑ No	
Kidney disease	❑ Yes ❑ No	
Liver disease	❑ Yes ❑ No	
Lung or respiratory disease	❑ Yes ❑ No	
Skin disease	❑ Yes ❑ No	
Stomach or intestinal ulcers	❑ Yes ❑ No	
An antibiotic-resistant infection (for example, methicillin-resistant *Staph aureus*)	❑ Yes ❑ No	

Medications, vitamins, and supplements I take:

Medications I CANNOT take due to allergy or adverse reaction

What kind of medications might Dr Duke use?

Antibiotics such as penicillin, Keflex, erythromycin, sulfa drugs, Cipro, Levaquin, or iodine;
Local anesthetics such as marcaine, lidocaine, or epinephrine;
Pain medications such as codeine, aspirin, acetaminophen (Tylenol), ibuprofen (Advil or Motrin), or naproxen (Aleve);
Other medical agents such as diazepam (Valium), radiographic dye, latex, or bandage tape.

REVIEW OF SYSTEMS

Date:_____

General Health			**Gastrointestinal**		
Do you feel well?	Yes	No	Constipation	Yes	No
Food allergy	Yes	No	Diarrhea	Yes	No
Seasonal allergy	Yes	No	Heartburn	Yes	No
Appetite loss	Yes	No	Hepatitis	Yes	No
Dietary changes	Yes	No	Nausea	Yes	No
Medication changes	Yes	No	Vomiting	Yes	No
Chills	Yes	No			
Fatigue	Yes	No	**Musculoskeletal**		
Obesity	Yes	No	Osteoarthritis	Yes	No
			Rheumatoid arthritis	Yes	No
			Back pain	Yes	No
Respiratory			Hip pain	Yes	No
Difficulty breathing	Yes	No	Fracture or broken bone	Yes	No
Asthma	Yes	No	Joint replacement	Yes	No
Bronchitis	Yes	No	Knee pain	Yes	No
Cigarette smoking	Yes	No			
Cough	Yes	No	**Neurological**		
Emphysema	Yes	No	Burning	Yes	No
			Headaches	Yes	No
			Numbness	Yes	No
Cardiovascular			Pins and needles	Yes	No
Chest pain	Yes	No	Seizures	Yes	No
Heart attack	Yes	No	Stroke	Yes	No
Heart disease	Yes	No			
Heart surgery	Yes	No	**Endocrine**		
Stent surgery	Yes	No	Increased appetite	Yes	No
Cramping in your calves	Yes	No	Increased thirst	Yes	No
High blood pressure	Yes	No	Increased urination	Yes	No
High cholesterol	Yes	No	Diabetes	Yes	No
Irregular heartbeat	Yes	No	Obesity	Yes	No
Rash	Yes	No	Thyroid disease	Yes	No
Shortness of breath	Yes	No	Weight loss	Yes	No
Swelling of feet or ankles	Yes	No	Weight gain	Yes	No