Ronald W. Alm, DPM PATIENT INTAKE FORM

PATIENT INFORMATION

LEGAL NAME: _____
Last First Middle

MAILING ADDRESS:_____
Street City State Zip Code

PRIMARY PHONE: _____ ALTERNATE PHONE: _____

EMAIL ADDRESS: _____ Is It ok to leave a message on your phone? ❑ Yes ❑ No

GENDER: ❑ Female ❑ Male SOCIAL SECURITY NUMBER: _____

MARITAL STATUS: ❑ Married ❑ Single ❑ Divorced ❑ Legally Separated ❑ Widowed ❑ Significant Other

DATE OF BIRTH: _____ Primary Care Physician: _____

DATE OF LAST VISIT TO PRIMARY CARE PHYSICIAN: _____

******Would you like the cost of today's treatments discussed in advance? ❑ Yes ❑ No (Payment is due at time of service.)**

SPOUSE'S/PARTNER'S NAME: _____

EMERGENCY CONTACT: _____
Name Phone Number Relationship to Patient

RESPONSIBLE PARTY, IF PATIENT IS A MINOR:

NAME: _____ DOB: _____ SOCIAL SECURITY NUMBER: _____
Last First

MAILING ADDRESS:_____ PHONE NUMBER: _____
Street City State Zip Code

NAME: _____ DOB: _____ SOCIAL SECURITY NUMBER: _____
Last First

MAILING ADDRESS:_____ PHONE NUMBER: _____
Street City State Zip Code

INSURANCE INFORMATION: ****** PLEASE HAVE INSURANCE CARDS AND PHOTO ID AVAILABLE ******

Is your visit today a result of a workplace injury, an accident or a verified workers' compensation claim? ❑ Yes ❑ No

What is your insurance Specialist Office Visit Co-pay? $ _____ What is your insurance deductible? $ _____

How much of your insurance deductible has been met this year to date? $ _____

Primary Insurance Company: _____ Subscriber Name: _____ DOB: _____

Secondary Insurance Company: _____ Subscriber Name: _____ DOB: _____

❑ No Insurance (Payment is due at time of service; please ask for an estimate in advance of the appointment.)

Consent for Treatment: I hereby authorize necessary medical care to be rendered to the patient registered hereon.

Release of Information/Financial Responsibility: I hereby assign any insurance benefits and authorize the release of medical information for the purpose of treatment, payment and healthcare operations to Dr. Ronald W. Alm, DPM for services rendered for which I acknowledge full financial responsibility.

_____ _____
Date **Signature of Patient/Beneficiary, Guardian or Personal Representative**

Please complete back side ⇨

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF OFFICE POLICIES

I understand that the office has policies that pertain to the office hours, my appointments, leaving messages for appointment reminders, transferring of records, the financial policies for payment, insurance verification, referrals, and statements for payment. I understand that a full document called *Notice of Office Policies* is available to me online through the website (www.doctoralm.com) and at the office.

I acknowledge that I was provided a copy of the *Notice of Office Policies* containing a more complete description of the policies of the office and the financial policies regarding payment, and that I have read (or had the opportunity to read if I so chose) and understood the *Notice*. I understand that this organization has the right to change its *Notice of Office Policies* from time to time and that I may contact this organization at any time to obtain a current copy of the *Notice of Office Policies*.

_____ _____

Signature of Patient/Beneficiary, Guardian or Personal Representative Date

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

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 among the 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 acknowledge that I was provided a copy of the *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information, and that I have read (or had the opportunity to read if I so chose) and understood the *Notice*. 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 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 used or disclosed to carry out treatment, payment or healthcare operations. I also understand you are not required to agree to my requested restrictions, but if you do agree, then you are bound to abide by such restrictions.

Patient Name _____

Relationship to Patient _____

Signature _____ Date _____

I give authorization to discuss my protected health information to the following:

_____ _____ _____

Name Relationship Date of Birth

OFFICE USE ONLY
I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:
Date _____ Initials _____ Reason _____

Ronald W. Alm, DPM **Medical History Form, p. 1**

Name_____ Age_____ Date of Visit_____

Height _____ Weight _____ Shoe size_____ Pharmacy _____

What specific problem brings you into our office today: Please indicate which foot (circle): Right Left Both

_____

_____

Primary Care Doctor (PCP): _____ Date Last Seen: _____

Referring Doctor: _____ **Are Treatment Costs a Concern? ❑ Yes ❑ No**

Is this visit related to a work-place injury? ❑ Yes ❑ No

Please list ***all*** medical conditions you are being treated for by a physician (i.e., high blood pressure, diabetes, cholesterol, asthma):

_____

_____

Please list all surgeries, diagnostic tests and procedures requiring anesthesia (i.e. colonoscopy, endoscopy, angiography, pacemaker):

_____

_____

Complications with anesthesia or surgery: ❑ Nausea/Vomiting ❑ Bleeding ❑ Hard time waking up ❑ Infection ❑ None

Have you ever had: 1) a MRSA infection? Yes No 2) Hepatitis B or C? Yes No 3) HIV / AIDS? Yes No

Your Social History:

Are you currently employed? ❑ Yes ❑ No Your Employer: _____ Occupation: _____

Recreational Activities:_____

Smoking Status: ❑ Current every day smoker _____ packs/day ❑ Current some day smoker ❑ Former smoker ❑ Never smoker

Do you drink alcohol? ❑ Yes ❑ No If yes, how many drinks/week?_____ Have you been treated for alcohol or drug abuse? _____

Personal Medical History – Please indicate *Yes* or *No* (or select the situation) to all conditions:

Recent fever	Yes	No	Emphysema / COPD	Yes	No	Stroke	Yes	No
Recent weight loss or gain NA	Gain	Loss	Asthma / Bronchitis	Yes	No	Bipolar	Yes	No
Diabetes / Borderline diabetic	Yes	No	Blood clot in lungs / legs	Yes	No	Depression	Yes	No
If yes, last A1C _____			Sleep apnea	Yes	No	Fainting	Yes	No
Insulin resistant	Yes	No	Use of C-PAP	Yes	No	Seizures	Yes	No
Dialysis	Yes	No	Use of oxygen	Yes	No	Numb Feet	Yes	No
Cancer	Yes	No	Had a chest X-ray	Yes	No	Joint pain (a.m.)	Yes	No
If yes, type _____			If yes, when _____			If yes, where _____		
Hospitalized in the last 5 years	Yes	No	If yes, where _____			Low Back Pain	Yes	No
If yes, why _____			High blood pressure	Yes	No	Arthritis	Yes	No
Bleeding problems	Yes	No	Chest Pain	Yes	No	Rheumatoid Arthritis		
Anemia	Yes	No	Heart attack	Yes	No	(RA)	Yes	No
Psoriasis/Eczema (if Yes, circle)	Yes	No	Irregular heartbeat	Yes	No	Fibromyalgia	Yes	No
Sweaty feet	Yes	No	Heart murmur	Yes	No	Osteoporosis	Yes	No
Hearing problem	Yes	No	Congestive heart failure	Yes	No	Acid reflux	Yes	No
Glaucoma	Yes	No	Had EKG w/in 6 months	Yes	No	Ulcer	Yes	No
Frequent sinus infections	Yes	No	Frequent infections	Yes	No	Bladder infection	Yes	No
Frequent sore throats	Yes	No	Slow healing	Yes	No	Kidney problem	Yes	No
Shortness of breath w/ exertion	Yes	No	Liver problems	Yes	No	Pregnant now	Yes	No

Name_____ Date of Visit_____

Family Medical History - Please check if a ***family member*** has had the following:

- ❑ Diabetes If, so, who? _____
- ❑ Heart disease If, so, who? _____
- ❑ High blood pressure If, so, who? _____
- ❑ Arthritis If, so, who? _____
- ❑ Stroke If, so, who? _____
- ❑ Anesthesia problems If, so, who? _____
- ❑ Bleeding disorders If, so, who? _____
- ❑ Rheumatoid arthritis If, so, who? _____
- ❑ Lupus If, so, who? _____
- ❑ Malignant hyperthermia If, so, who? _____
- ❑ Other _____
- ❑ Cancer - If yes, who and what kind? _____

Are you taking aspirin? ❑ Yes ❑ No

Allergies

Are you allergic to any of the following? ❑ Tape ❑ Latex ❑ Iodine ❑ Other _____

Are you allergic to any medications? ❑ Yes (list below) ❑ None known

Name of Medication	Type of Reaction
_____	_____
_____	_____
_____	_____

Medications You Are Currently Taking

**** Or provide us a list and we will copy that instead ****

Medication Name and Dosage	Reason for taking this medication?
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____