Patient Information:

Patient Name: _____ **Gender**: ❑M ❑ F
First **Middle** **Last**

SSN: _____ **DOB**: _____ **Email**: _____

Mailing Address: _____
Street **City** **State** **Zip Code**

Home Phone: (_____) _____-_____ **Work Phone**: (_____) _____-_____

Cell Phone: (_____) _____-_____ **Upon contact, whom may we speak with**: Patient | Spouse | Parent

Employer: _____ **Employer Phone**: (_____) _____-_____

Emergency Contact: _____ **Relationship to patient:** _____

Emergency Phone: (_____) _____-_____

Does the patient have a POWER OF ATTORNEY? YES❑ NO❑ (If yes, please ask for corresponding paperwork.)

Government Mandated Information: (ALL fields required) Primary Language: _____

Race: American Indian | Asian | Pacific Islander | African American | Caucasian **Ethnicity**: Hispanic/Latino | Non-Hispanic/Non-Latino

Marital Status: Single | Mar | Div | Wid **Student Status**: Part-time | Full-time | N/A **Employment Status**: Part-time | Full-time | N/A

Insurance Information: (ALL fields required if policy holder is not the patient, if policy holder is the patient simply circle self)

Primary Insurance Company: _____ **Policy Holder's Name**: _____

Birthdate: _____ **Policy holder's relationship to patient: Self | Father | Mother | Spouse | Other** _____

Secondary Insurance Company: _____ **Policy Holder's Name**: _____

Birthdate: _____ **Policy holder's relationship to patient: Self | Father | Mother | Spouse | Other** _____

If patient is a minor, who is financially responsible for services and/or products provided? (Please complete section below)

Name: _____ **DOB:** _____ **Phone:** _____

Mailing Address: _____
Street **City** **State** **Zip Code**

Attention:

- I authorize the release of all information to my insurance companies, workers compensation carriers, and/or other treating physicians.
- I authorize the physicians of Lafayette Podiatry Associates, P.C. to treat my foot/ankle problems.
- I authorize Lafayette Podiatry Associates, P.C. to act as my agent in helping obtain payment from my insurance companies and to help me obtain any required pre-certification.
- I authorize and request insurance payment directly to Lafayette Podiatry Associates, P.C.
- If insurance deems my procedure not medically necessary, I will be responsible for payment. Some items that may be denied include, but are not limited to COVERED FOOT CARE and DURABLE MEDICAL EQUIPMENT, such as walker boots, ankle braces and custom orthotics.
- I understand that all over the counter and durable medical products must be returned within 30 days of dispense to receive credit or refund.
- I agree to pay for my bill in full plus court costs, attorney fees, and all collection fees if deemed necessary.

_____ _____

PATIENT/PARENT SIGNATURE **DATE**

Medical History

Patient Name: _____ **DOB:** _____

Height: _____ **Weight:** _____ **Shoe size:** _____ **Do you have Diabetes?** Y N

Primary Physician: _____ **Referring Physician:** _____

Pharmacy & Location: _____

Do we have permission to access your medication history from your pharmacy? Y N
(If you do not allow access, you must provide a list of all mediations you are currently taking.)

What type of foot/ankle problem are you having? _____

_____

Do you exercise or participate in any types of sport activities, what type? _____

_____

Social History:

Do you smoke? Yes No **What do you smoke?** _____ **Number of packs per day is** _____ **How long have you been a smoker?** _____	**If not a current smoker, have you ever been a smoker?** Yes No **If yes, how long ago did you quit?** _____	**Do you use alcohol?** Yes No **If yes, how often?** Rarely Often Socially

Medical History: (please check all that apply)

Arthritis	**Cancer**	**Gout**	**Heart Attack**	**Hepatitis**
High Cholesterol	**HIV/Aids**	**Injury/Fracture**	**Osteoporosis**	**Stroke**
Rheumatoid Arthritis	**Diabetes 1 or 2**	**Ulcers**	**High Blood Pressure**	**Kidney Disease**
Thyroid Disease	**Psoriasis**	**Other**	**Other**	**Other**

Surgical History:

Allergies:

_____ _____

PATIENT/PARENT SIGNATURE **DATE**

Current or former patients only: ☐ **Changes made** ☐ **No changes** _____

Initial/Date

Lafayette Podiatry Associates, P.C.

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Fax (765) 449-0659
www.lafayettepodiatry.com

ACKOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES & INFORMATION RELEASE

I acknowledge that I was offered a copy of the Notice of Privacy Practices and that I have read or had the opportunity to read if I so choose. I understand and agree to the terms in the notice.

(If you would like a copy of the notice for your records, please inform the front desk staff)

I _____ give permission for Lafayette Podiatry
(Patient Name)
Associates, P.C. to release any information related to: (Please check all that apply)

☐ My Appointments ☐ Billing Information ☐ Medical Information

This information may be released to:

☐ My spouse: _____
(Spouse Name)

☐ My POA: _____
(POA Name)

☐ Other: _____ _____
(Name) (Relationship)

☐ I do not authorize my information to be released to anyone.

Authorization date: _____
This authorization will NOT expire unless requested by the patient/guardian in writing.

Patient Signature: _____

Office Staff Witness: _____