Patient Information Form

Patient Name_____ Date of Birth: ___/___/____

(Last) (First) (MI)

Home Address:_____ City/State_____ Zip:_____

Home #:_____ Work #:_____ Cell #:_____

** **Email:**_____SSN:_____

Marital Status:_____ Age:_____ Sex: M F

Legal Guardian (POA):_____ Relationship:_____ Phone:_____

Emergency Contact:_____ Relationship:_____ Phone:_____

** **Primary Care Doctor:**_____ Location:_____ Phone:_____

Pharmacy:_____Location:_____ Phone:_____

Who is responsible for Payment?:_____ Relationship:_____

Address:_____ City/State:_____ Zip:_____ Phone:_____

Who Referred you to us?_____

INSURANCE INFORMATION

Primary Company Name:_____Contract:_____ Group:_____

Address:_____City/State:_____ Zip:_____ Phone:_____

Insured Name:_____ DOB:_____ Employer:_____

Secondary Company Name:_____Contract:_____ Group:_____

Address:_____City/State:_____ Zip:_____ Phone:_____

Insured Name:_____ DOB:_____ Employer:_____

GCP Staff Use: BP:_____ **T:**_____ **P:**_____ **R:**_____

Your Medical History: ** **Height:**_____ ** **Weight:**_____lbs

ALLERGIES: Medications:_____ Other:_____

Anesthesia:_____ Foods:_____ Tape:_____ NONE:_____

Have you ever had any of the Following?: (please Circle)

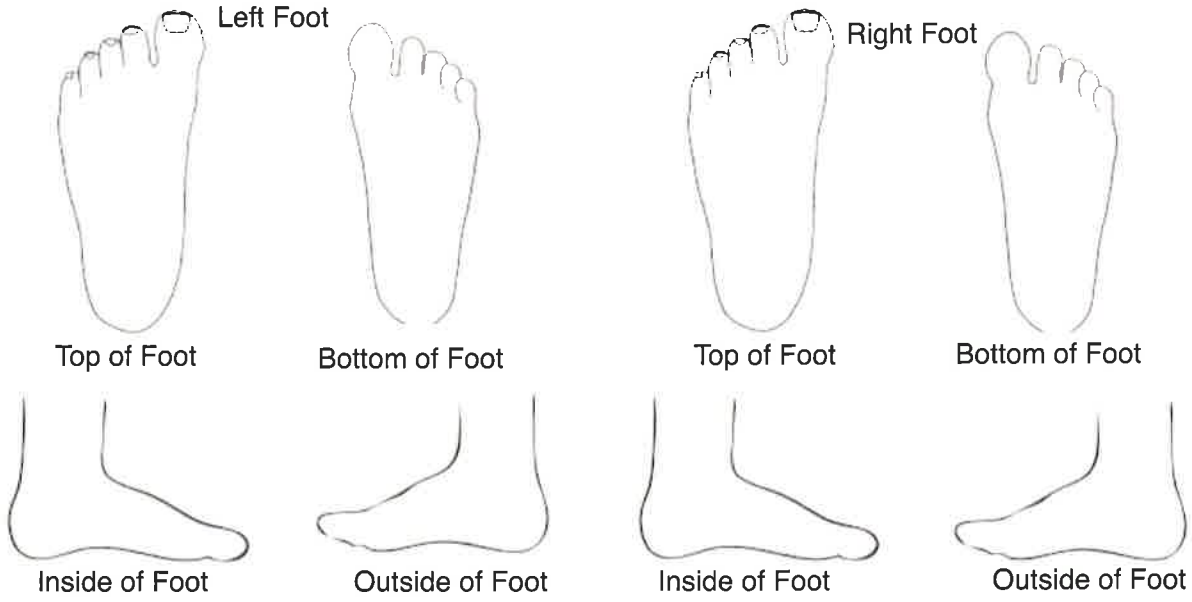
Acid Reflux	Fibromyalgia	Mitral Valve Prolapse
Anemia	Gout	Neuropathy
Arthritis	Heart Attack	Open Sores
Asthma	Heart Disease / Failure	Pneumonia
Back Trouble	Hepatitis	Rheumatic Fever
Bladder Infections	HIV / AIDS	Sickle Cell Disease
Abnormal Bleeding	High Blood Pressure	Skin Disorder
Blood Clots	High Cholesterol	Sleep Apnea
Blood Trasfusion	Kidney Disease	Stomach Ulcers
Bronchitis / Emphysema	Liver Disease	Stroke
Cancer	Low Blood Pressure	Thyroid Disease
Diabetes	Migraine Headaches	Tuberculosis

Other Conditions:_____

CURRENT PROBLEM:

What Specific Problem brings you into our office today?_____

Where is the Pain? (please mark below) How bad is the pain? _____



SHAYNE JENSEN, DPM ADAM PEADEN, DPM

PHONE: 850-769-0325 - FAX: 850-769-4476

CONSENT FOR PURPOSES OF TREATMENT, PAYMENT, AND HEALTHCARE OPERATIONS

I consent to the use or disclosure of my protected health information by Gulf Coast Podiatry for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills, or to conduct health care operations of Gulf Coast Podiatry. I understand that diagnosis or treatment of me by Dr. Shayne Jensen, and Dr. Adam Peaden may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment. payment, or healthcare operations of the practice. Gulf Coast Podiatry is required to agree to the restrictions that I may request. However, if Gulf Coast Podiatry agrees to a restriction request, the restriction is binding on Gulf Coast Podiatry and Dr. Shayne Jensen and Dr. Adam Peaden.

I have the right to revoke this consent, in writing, at any time, except in the extent that Dr. Shayne Jensen and Dr. Adam Peaden or Gulf Coast Podiatry has taken action in reliance of this consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician , another health care provider, a health plan, my employer, or a health care clearinghouse. This protected health information relates to my past, present, or future physical or mental health condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have the right to review Gulf Coast Podiatry's Notice of Privacy Practices prior to signing this document. The notice of privacy practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills, or in the performance of health care operations of Gulf Coast Podiatry. The notice of privacy practices for Gulf Coast Podiatry also describes my rights and Gulf Coast Podiatry's duties with respect to my protected health information.

Gulf Coast Podiatry reserves the right to change the privacy practices that are described in the notice of privacy practices. I may obtain a revised notice of privacy practices by calling the office and requesting a revised copy be sent by mail or asking for one at the time of my next appointment.

_____ _____

Signature of Patient Date

_____

Print Name of Patient

Consent for Photography, Videotaping, or Other Imaging for Media or Educational Purposes

Patient's Name: _____ Patient's Date of Birth: _____

I give my consent to have photographs, videotaped images, or other images made of _____ .I understand and agree that these images may be used by Gulf Coast Podiatry, for the purpose outlined below.

_____ Teaching purposes, which includes being shown to other patients.

_____ Advertisements by Gulf Coast Podiatry

_____ Placement on Gulf Coast Podiatry's website

_____ Other

_____

_____

Signature of patient/legal representative

If legal representative, relationship to patient _____

_____

Date

Patient Name:_____ Date of Birth:_____

Please List **ALL MEDICATIONS** you are currently taking (including prescription, over the counter, and herbal medications): ** can attach separate sheet

Name	Dose	How often do you take?

Please list **ALL prior Surgeries:** ** can attach separate sheet

Type of Surgery	Date	Type of Surgery	Date

Social History:

Alcohol: __ Never __ No longer use __ History of Abuse __Rare
Type:_____ __ Moderate __ Daily __ Occasional

Tobacco: __ Never __ No longer use - Quit how long ago?_____ __Rare
Type:_____ __ Moderate __ Daily __ Occasional

Recreational Drugs: __ Never__ No longer use - Quit how long ago?_____ __Rare
Type:_____ __ Moderate __ Daily __ Occasional

How much are you on your feet at work? ___10% ___25% ___50% ___75% ___100%

** Family History:	Type	** Maternal or Paternal
Heart Disease		
Diabetes		
Cancer /Other		