Dr. Ronald Sheppard DPM, FACFAS
Board Certified Foot Surgeon
Diplomate-American Board of Podiatric Surgery

NAME:_____ **SEX: M F**

ADDRESS:_____

TOWN:_____ **ZIPCODE:**_____

HOME PHONE #:_____ **CELL PHONE #:** _____

SSN #: _____-____-_____ **BIRTHDATE:** _____

MARITAL STATUS: S M D W

OCCUPATION:_____

E-MAIL ADDRESS: _____

Primary Language_____ **Race**_____ **Ethnicity: Are you Hispanic or Latino:** Y N

PHARMACY NAME: _____ **LOCATION:** _____ **PHONE:** _____

WHAT IS THE MAIN REASON FOR YOUR VISIT TODAY?

_____

HOW WERE YOU REFERRED TO THE OFFICE?

☐ Internet Search ☐ Insurance Company ☐ Other Physician: _____

☐ Friend/Patient: _____ ☐ Other: _____

PRIMARY INSURANCE:

INSURANCE COMPANY_____

NAME OF CARD HOLDER_____

ID NUMBER: _____ GROUP NUMBER_____

INSURED BIRTHDATE _____

INSURED SOCIAL SECURITY #_____

SECONDARY INSURANCE:

INSURANCE COMPANY NAME:_____

NAME OF CARD HOLDER_____

ID NUMBER: _____ GROUP NUMBER_____

INSURED BIRTHDATE :_____

INSURED SOCIAL SECURITY # :_____

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NAME_____ **DOB**_____

PATIENT HISTORY

Sex M F
Height_____ Weight_____
Last Known Blood Pressure _____/_____

Do you smoke? Current Former Never
If yes, how much?_____

Do you drink alcohol? YES NO
If yes, how much?_____

Are you being treated for or have you ever been treated for (please check all that apply):

_____**High Blood Pressure (Hypertension)**
_____**Diabetes**
_____Asthma
_____Syncope (Fainting issues)
_____Thyroid Conditions
_____Liver Disease or Hepatitis
_____High Cholesterol
_____Heart Trouble (CAD)
_____Kidney Disease
_____Circulation Issues (PVD)
Other (please list): _____

Have you had any past **SURGERIES**? **YES NO**

If yes, what type and when? (please list)

SURGERY	**Date**
_____	_____
_____	_____
_____	_____

Do you have a PRIMARY CARE PHYSICIAN? Yes____ No____
Name:_____

Address:_____

Phone #:_____

Date last seen:_____

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List all medications you are presently taking:

Medication:	**Amount/Frequency:**
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Are you subject to **prolonged bleeding** ? **YES** **NO**
If **yes**, do you take a blood thinner? (I.E Coumadin or Aspirin) **YES** **NO**

Do you have any **ALLERGIES** to drugs, medicines, or other substances? **YES** **NO**
Is **yes**, please list: _____

We are required by the government ACA Act to ask the following questions for data collection:

If you are 65 years old or older have you received your **PNEUMONIA VACCINE** within the last 5 years? **YES** **NO** **DOES NOT APPLY**

If you are 50-75 years old have you had a COLORECTAL CANCER SCREENING?
YES **NO** **DOES NOT APPLY**

If **YES** was it (please circle): **COLONOSCOPY** or **FLEX. SIGMOIDOSCOPE ?**

Have you had your **FLU SHOT**? **YES** **NO**
If **yes**, when? _____

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MEDICAL INSURANCE AUTHORIZATION

SIGNATURE ON FILE

- I authorize use of this form on all my insurance submissions.
- I authorize release of necessary information to all my insurance carriers.
- I authorize my doctor's staff to act as my agent in helping me obtain payment from my insurance carrier.
- I authorize payment from my insurance carrier directly to my doctor.
- I permit a copy of this authorization to be used in place of the original.

Patient's Name: _____

Signature: _____

Date: _____

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ACKNOWLEDGMENT 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 chose) and understood the notice.

_____ _____
Patient Name (please print) Date

_____
Signature

Relationship to patient:

Self: _____

Parent: _____

Authorized representative:_____

I give permission to the following person to access my medical records:
Name: _____
Relationship to patient: _____

SUMMARY OF NOTICE OF PRIVACY PRACTICES

This summary is provided to assist you in understanding the attached Notice of Privacy Practices

The attached Notice of Privacy Practices contains a detailed description of how our 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 health care 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 health care providers. Finally, we may disclose your health information for certain limited operational activities such as quality assessment, licensing, accreditation and training of students.

Uses and Disclosures Based on Your Authorization. Except as stated in more detail in the 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 may disclose your health information without your written authorization:

- To family members or close friends who are involved in your health care;
- For certain limited research purposes;
- For purposes of public health and safety;
- To Government 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 to 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 communicate with you in confidence;
- To request that we amend your health information;
- To receive notice of our privacy practices.

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