

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)**

_____ Liver Disease or Hepatitis

_____ **Diabetes**

_____ High Cholesterol

_____ Asthma

_____ Heart Trouble (CAD)

_____ Syncope (Fainting issues)

_____ Kidney Disease

_____ Thyroid Conditions

_____ 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**
If **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? _____

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: _____

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: _____