WELCOME TO OUR OFFICE

Please provide the Following Important Information
(All information is kept private and confidential)

PATIENT NAME _____ *SS#* _____

PATIENT ADDRESS _____ *CITY* _____ *ST* _____ *ZIP* _____

DATE OF BIRTH _____ *AGE* _____ *SEX: MALE FEMALE (Circle one) MARITAL STATUS: M S W D*

HOME PHONE _____ *CELL PHONE* _____ *OTHER* _____

NAME OF SPOUSE/PARENT/GUARDIAN _____ *PHONE* _____

ADDRESS OF SPOUSE/PARENT/GUARDIAN _____ *PHONE* _____
(If same write "SAME")

NAME OF FAMILY PHYSICIAN _____ *PHONE* _____

DID YOUR FAMILY PHYSICIAN REFER YOU TO OUR OFFICE? Y N REFERRED FOR:__ 2nd OPINION __ SURGICAL EVALUATION __CONSULT

NAME OF REFERRING PHYSICIAN: _____ *REFERRED FOR:__ 2nd OPINION __ SURGICAL EVALUATION __ CONSULT*
(If other than family physician)

NAME OF EMPLOYER/SCHOOL _____ *PHONE* _____

ADDRESS OF EMPLOYER _____ *CITY* _____ *ST* _____ *ZIP*_____

STATUS OF EMPLOYMENT/SCHOOL (Please circle one)) FULL TIME PART-TIME RETIRED OTHER OCCUPATION: _____

PRIMARY INSURANCE INFORMATION

NAME OF INSURANCE _____ *INSURED DATE OF BIRTH* _____

NAME OF INSURED _____ *SS#* _____
(Person who carries insurance))

INSURED ADDRESS _____ *CITY* _____ *ST* _____ *ZIP* _____
(If same write "SAME")

INSURED PHONE _____ *RELATIONSHIP TO PATIENT SELF SPOUSE PARENT GUARDIAN*

NAME OF EMPLOYER _____ *PHONE* _____

EMPLOYER ADDRESS _____ *CITY* _____ *ST* _____ *ZIP* _____

SECONDARY INSURANCE INFORMATION

NAME OF INSURANCE _____ *INSURED DATE OF BIRTH* _____

NAME OF INSURED _____ *SS#* _____
(Person who carries insurance)

INSURED ADDRESS _____ *CITY* _____ *ST* _____ *ZIP* _____
(If same write "SAME")

INSURED PHONE _____ *RELATIONSHIP TO PATIENT SELF SPOUSE PARENT GUARDIAN*

NAME OF EMPOLYER _____ *PHONE* _____

EMPLOYER ADDRESS _____ *CITY* _____ *ST* _____ *ZIP* _____

Patient Name: _____

MEDICAL HISTORY:

HAVE YOU BEEN TREATED FOR/OR DO YOU HAVE: Please check all that apply

___ Broken foot bone(s)
___ Broken Ankle
___ Ankle Sprain
___ Arch Pain
___ Knee Pain
___ Lower Back Pain
___ Leg Cramps/Stiff Joints
___ Gait (Walking) Problems
___ Childhood Foot Problems
___ Toe-Walking
___ Toeing-In
___ Flat Feet
___ Rash
___ Corns/Calluses
___ Bunions
___ Hammer Toes
___ Heel Pain
___ High Arches
___ Neuroma
___ Numbness in feet
___ Ingrown Nails
___ Fungus Nails
___ Athlete's foot
___ Warts
___ Leg or Foot Ulcers
___ Severe Ankle Swelling
___ Other
___ Stroke
___ Heart Attack
___ Heart Problems
___ Hearing/Ear Problems
___ Nerve Disorder
___ Osteoporosis
___ Liver Disease
___ High Blood Pressure
___ Vascular Disease
___ Kidney Disease
___ Poor Circulation
___ Psychiatric Disorder
___ Chicken Pox
___ Rheumatic Fever
___ Tuberculosis
___ Lymes Disease
___ Stomach Ulcers
___ Lung Disease
___ Gout
___ Phlebitis
___ Hepatitis
___ Thyroid
___ Diabetes
___ Cancer
___ Anemia
___ Asthma
___ Epilepsy
___ Thick Scar
___ Arthritis
___ Measles
___ Mumps
___ Glaucoma
___ Alzheimer's
___ Headaches
___ Sciatica
___ NONE ABOVE

PLEASE LIST PAST SURGERIES

TYPE OF SURGERY	DATE OF SURGERY	COMPLICATIONS
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

PLEASE LIST ALL MEDICATIONS YOU ARE TAKING

MEDICATION	DOSAGE	TAKING MEDICATION FOR
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Are you taking your medications as your doctor prescribed? YES NO
What Pharmacy do you regularly deal with:
Pharmacy name: _____ Phone: _____

ALLERGIES: Please check all that apply.

ALLERGY	TYPE OF REACTION
___ Penicillin	_____
___ Other antibiotics	_____
___ Codeine	_____
___ Demerol	_____
___ Phenergan	_____
___ Other Narcotics	_____
___ Novocaine	_____
___ Sulfa Drugs	_____
___ Aspirin	_____
___ Barbiturates	_____
___ Erythromycin	_____
___ Tylenol	_____
___ Advil, Aleve, Motrin	_____
___ Adhesive Tape	_____
___ Shrimp, iodine,Merthiolate	_____
___ Other	_____

FAMILY MEDICAL HISTORY The following questions are regarding immediate family (parents, grandparents, siblings, and children)

	ILLNESS	RELATIONSHIP TO PATIENT
____	Heart Problems	_____
____	Heart Attack	_____
____	High Blood Pressure	_____
____	Leg/Foot Deformities	_____
____	Nail problems (ingrown/fungus)	_____

	ILLNESS	RELATIONSHIP TO PATIENT
____	Arthritis	_____
____	Stroke	_____
____	Cancer	_____
____	Asthma	_____
____	Diabetes	_____

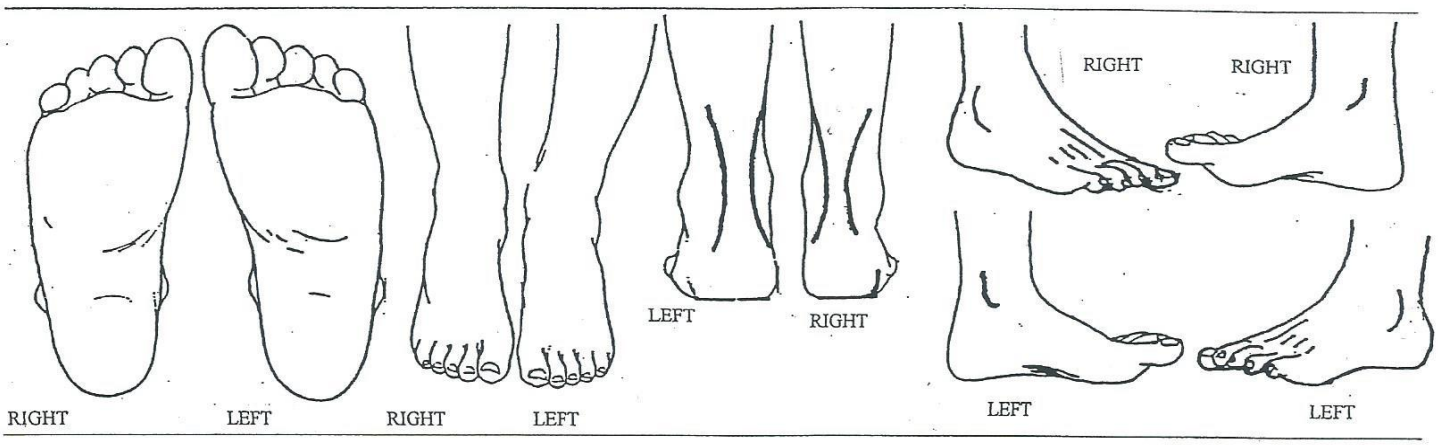
PLEASE ANSWER THE FOLLOWING QUESTIONS:

1) Do you wear or have you ever worn:
   A) Orthotics YES NO Are you still wearing them? YES NO Did they help you? YES NO
   B) Shoe Inserts YES NO Are you still wearing them? YES NO Did they help you? YES NO
   C) Who prescribed the above? _____
2) What percentage of your day is spent standing on your feet? 20% 40% 50% 60% 80% 100%
3) Do you smoke? YES NO Did you quit? YES NO
   # of packs per day _____ When did you Quit? _____
4) Date you last saw your family doctor _____
5) Do you drink Alcoholic beverages? YES NO
6) Do you take recreational drugs? YES NO
7) What is your: HEIGHT: _____ WEIGHT: _____
   SHOE SIZE: _____

PATIENT'S PRIMARY COMPLAINT:

Patient Name: _____

Please put a #1 on the diagram below to indicate the area of your primary complaint.
Please put a #2 on the diagram below to indicate the area of your secondary complaint.



My primary complaint is on my: _____ right foot _____ left foot _____ both feet
Please describe your primary complaint. _____

What type of pain/discomfort are you having? __ Shooting pain __ Throbbing pain __ Sharp pain __ Burning pain __ Aching pain
(Please check all that apply) __ Dull pain __ Tenderness __ Itching __ Tingling __ Numbness

How would you rate your pain? ____ None _____ Light _____ Moderate _____ Strong _____ Severe

When did your symptoms start? _____ Do you feel your symptoms are: ___ worsening ___ staying the same ___better
Is this problem work related? _____ When did injury occur? _____ Date reported to employer: _____

My secondary complaint is on my: _____ right foot _____ left foot _____ both feet
Please describe your secondary complaint. _____

What type of pain/discomfort are you having? __ Shooting pain __ Throbbing pain __ Sharp pain __ Burning pain __ Aching pain
(Please check all that apply) __ Dull pain __ Tenderness __ Itching __ Tingling __ Numbness

How would you rate your pain? ____ None _____ Light _____ Moderate _____ Strong _____ Severe

When did your symptoms start? _____ Do you feel your symptoms are: ___ worsening ___ staying the same ___better
Is this problem work related? _____ When did injury occur? _____ Date reported to employer: _____

PLEASE ANSWER THE FOLLOWING QUESTIONS:

1) Are your first steps out of bed painful? Y N ...then subside? Y N
2) Do you get leg cramps during the day? Y N ...at night? Y N
3) Does foot pain limit your activities? Y N
4) Does your foot problem cause any difficulty in walking? Y N
5) Any pain in calves or buttocks when walking? Y N
6) Is the pain relieved by stopping and standing still? Y N
7) Are you slow to heal after cuts? Y N
8) Any abnormal bruising, bleeding or scarring? Y N
9) Are you currently taking any medications? Y N ... insulin? Y N
10) Are you taking vitamins or supplements that contain: __ garlic __ Gingko biloba __ echinacea __ ginseng __ St. John's Wort
11) Do you have vascular grafts Y N
12) Do you have implants? Y N
13) Did you have heart valves replacement? Y N

DOCTORS SIGNATURE: _____ DATE: _____

(OVER)

Patient name: _____

West Ten Podiatry Centre, Inc.

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I authorize West Ten Podiatry Centre, Inc., and any associated physician to release information concerning the medical history and treatment for purposes of insurance claim processing. I have read, understood and accurately answered all questions above and assume responsibility for payment of account (including those fees which are not paid through medical insurance).

SIGNATURE _____ **DATE** _____

AUTHORIZATION FOR PAYMENT

I request that payment of authorized medical insurance benefits be made on my behalf to West Ten Podiatry Centre, Inc. for any services furnished to me by that physician. I authorize any holder of medical information about me to release to the health care financing administration or the involved health insurance company and its agents any information needed to determine these benefits or the benefits payable to related services.

SIGNATURE _____ **DATE** _____

AUTHORIZATION OF TREATMENT FOR A MINOR

I, _____, hereby give the person(s) listed below consent/permission to authorize treatment for my
(Name of parent/guardian)

my minor child _____ from the physicians at West Ten Podiatry Centre, Inc. This permission enables West Ten
(Name of patient)

Podiatry to obtain a history, examine the child, administer anesthesia, and perform procedures.

_____ _____
(Name of person authorized to give consent) (Relationship to patient)

_____ _____
(Name of person authorized to give consent) (Relationship to patient)

SIGNATURE _____ **DATE** _____

AUTHORIZATION TO RELEASE PRIVATE/MEDICAL INFORMATION

I authorize West Ten Podiatry to release private/medical information to the following:

_____ _____
(Name of person authorized to receive information) (Date of birth /relationship to patient)

_____ _____
(Name of person authorized to receive information) (Date of birth/relationship to patient)

HIPAA PRIVACY NOTIFICATION

West Ten Podiatry Centre, Inc. has provided me with their HIPAA compliant notice of privacy practice policy.

SIGNATURE _____ **DATE** _____

NOTICE OF PRIVACY PRACTICES STATEMENT

Dear Patient,

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE READ IT CAREFULLY.

YOUR PRIVACY IS IMPORTANT TO US.

At West Ten Podiatry Centre we are committed to providing you with the best medical care and service. And while information about you is fundamental to our ability to accomplish this, we fully recognize the importance of keeping personal and account information secure.

In order to offer you the best medical care and service, West Ten Podiatry Centre may need to share information about you both within West Ten Podiatry Centre and outside of West Ten Podiatry Centre with other medical facilities, physicians, and with insurance companies. This allows us to offer you and provide you with the best medical care and services that you require and to best meet your needs. We want you to understand our information safeguards, what information we collect, what information we share and what information is necessary for us to share in order to benefit you and your medical care.

This notice describes the privacy practices of West Ten Podiatry Centre Inc. governed by the laws of Pennsylvania and the United States of America. This notice explains West Ten Podiatry Centre's information collection and sharing practices. It lets you choose whether or not West Ten Podiatry Centre may share certain information about you, either within West Ten Podiatry Centre or outside of West Ten Podiatry Centre with other hospitals, physicians and/or insurance companies.

SECURITY PROCEDURES

West Ten Podiatry understands the importance of protecting and securing the privacy of your medical information and using it appropriately. Access to your medical information is restricted to West Ten Podiatry Centre and:

1. Those who assist us in providing you with medical care and treatment, when appropriate (e.g.: Hospitals, Other physicians involved with your care, laboratories) and
2. Those who assist us in your insurance claim processing when appropriate (e.g.: Insurance Companies, Electronic Claim providers.)

West Ten Podiatry Centre complies with the federal standards for the security of your medical/personal information.

When West Ten Podiatry Centre is required to share information about you with other hospitals, other physicians, insurance companies, Attorneys or others we require them to impose safeguards and use the information only for the permitted purpose. We also limit the amount of information shared, to what is appropriate. West Ten Podiatry Centre maintains an accounting disclosure list of non-routine disclosures of your medical record.

INFORMATION WE COLLECT

West Ten Podiatry Centre collects and uses personal information about you in order to conduct our business and to deliver to you the quality of service you expect from us. Sources of information include:

Patient information demographics (e.g.: address, telephone number, social security number, date of birth, etc.)
Patient history information (e.g.: family history, social history, allergies, medications etc.)
Problem history (e.g.: current medical condition)
Personal history (e.g.: family physician, your employer, spouse's employer, insurance carrier, etc.)

(OVER)

INFORMATION WE SHARE WITHIN WEST TEN PODIATRY CENTRE

West Ten Podiatry Centre may need to share all of the information we collect about you with other physicians and employees within West Ten Podiatry Centre in order to better serve your medical or financial (insurance) needs.

INFORMATION WE SHARE WITH OTHERS

When addressing your medical care and treatment it is sometimes necessary to share your medical/personal information with hospitals and other health care providers, family members and others whose interests are also providing you with the best medical care.

When addressing your insurance claim needs it is necessary to share your medical/personal information with your insurance company in order to process your claims. In certain circumstances, such as electronic claim filing, your information is sent through an insurance clearinghouse that forwards the information to your insurance company.

When necessary, your medical/personal information may need to be shared with an Attorney, legal and/or law enforcement agencies.

In all of these circumstances, West Ten Podiatry Centre will abide by the applicable laws protecting your medical/personal information.

OTHER INFORMATION USES AND DISCLOSURES

The following descriptions include examples. Not every possible use or disclosure for treatment, payment and health care operations purposes will be listed.

TREATMENT: We share and discuss a patient's medical information with other practice physicians, other office medical staff involved in your care, outside physicians whom we refer or consult in you care, hospitals or surgery centers, outside laboratories, radiology centers, home health agencies, durable medical equipment agencies or other facilities where we refer you for treatment and/or testing. (Example: A copy of your lab results may be sent to your family physician or other specialist we refer you to for further treatment.)

PAYMENT: We share only the necessary information to submit claims, the necessary information required by insurance companies to determine coverage eligibility and covered services, quality assurance audits, billing statements to designated family member, collection agencies, attorneys and consumer reporting agencies. (Example: Your social security number is the same as your insurance company policy number)

HEALTH CARE OPERATIONS: Activities conducted to operate the practice include a patient sign in sheet, the paging of patients in the waiting room when it is time to go to the examining room, making appointment reminder calls, including leaving messages on answering machines or with the person answering the phone, notification of test results by mail or fax, billing statements with our name and address, and the corporation attorney for any legal issues.

INFORMATION ABOUT YOUR CHOICE

We at West Ten Podiatry Centre are dedicated to servicing your medical needs and respect your choices related to your privacy. You may choose to tell us not to share specific information related to your medical/personal information. You are entitled to a copy of our privacy practices. By submitting a written request to our office, you have the right to file a complaint with our office if you believe your privacy rights have been violated. With written authorization, and if reasonably applicable, you have the right to authorize other uses and disclosures. You have the right to inspect, amend, correct, complete, copy and obtain an accounting of disclosures.

GENERAL INFORMATION

This information is being provided to you so that you are advised of how your medical/personal information is used. West Ten Podiatry Centre will only use your information to provide medical care and treatment, to assist you in processing your insurance claims and according to the laws established by the state of Pennsylvania and the United States of America.

The terms of this notice apply to all records containing your individual identifiable health information that are created or retained by our practice. We reserve the right to revise or amend this Notice of Privacy Practices. Any revision or amendment to this notice will be effective for all of your medical records that our practice has created or maintained in the past or create and maintain in the future. Our practice will post a copy of our current notice in our office waiting area. You may also request a copy of our most current notice at any time. We respect your right to privacy.