I authorize Dr. Nelson to:

Provide diagnostic and treatment services

Furnish my insurance company or Medicare with all the necessary information regarding my present illness or injury

Accept payment of medical benefits for medical supplies or services provided, with understanding that any overpayment will be reimbursed to me promptly.

By signing below, you have read and agree to our Financial Policy.

Payment is REQUIRED at the time services are rendered. If you are unable to pay for your visit, we will need to reschedule your appointment. Also, any missed appointments without letting us know 24 hours in advance will have a $25 charge.

Patient ______________________ Date ______________

Patient/Guardian ______________________ Date ______________

ALL PAPERWORK MUST BE FILLED OUT!

Were you injured at work?

Yes or No

Patient Name ____
Last First Middle

Mailing Address _________________________ City_______________ Zip________

Patient SS#____________________________ Birthday_________________________

Marital Status (S)__ (M)__ (D)__ (W)__

Best Number to reach you _________________________ Cell ___________________

Home Phone _________________________ Other______________________________

How would you like to be contacted for your reminder call? Choose one:

Home phone __ Cell phone __ Text__ or Email__.

Email address ____

Name of Primary Insurance ____

Policy Holder Name______________________________ Relationship _____________

Birthday________________________ Policy ID # _______________________________

Name of Secondary Insurance ____

Policy Holder Name _____________________________ Relationship ______________

Birthday _______________________ Policy ID # _________________________________

Have you seen a Podiatrist before? Yes ___ No ___

If yes, who? Name ____________________________ Last Visit ____________________

If patient is a minor or has a guardian, please fill out the responsible party.

Responsible party _______________________________ Relationship ______________

Address _________________________________ City_______________ Zip ________

Phone Number(s) ____

Chief complaint for which you came to be treated? ______________________________

____

Medical History

Parents deceased? Yes or No: Mother__________________ Father_________________

Mother medical history ____

Father medical history ____

Are you allergic to: Adhesive tape __ Local Anesthetics __ Anticoagulant Therapy __
Novocain__ Aspirin __ Penicillin __ Codeine __ Seafood __ Demerol __ Sulfa __ Iodine__

Other Allergies: ____

____

Medications including prescriptions, over-the-counter medications and vitamins:

____

____

____

____

All surgeries you have had: ____

____

____

____

Family Doctor _________________________________ Phone ______________________

Pharmacy ____________________________________ Phone ______________________

Home Health Agency _____________________________ Phone __________________

Medical History

Circle all that apply: Past or Present

Aids/HIV	Yes	No	Gout	Yes	No
Alzheimer	Yes	No	Heart Disease	Yes	No
Anxiety	Yes	No	Hepatitis A, B, C	Yes	No
Arthritis	Yes	No	Hyper Cholesterol (high)	Yes	No
Asthma	Yes	No	Hypo Cholesterol (low)	Yes	No
Atrial Fibrillation	Yes	No	Hypertension (high)	Yes	No
Bipolar Disorder	Yes	No	Hyperthyroidism (high)	Yes	No
Blood Clots	Yes	No	Hypothyroidism (low)	Yes	No
Cancer	Yes	No	Insomnia	Yes	No
Cancer Type			Kidney trouble	Yes	No
Cardiac	Yes	No	Liver trouble	Yes	No
Cellulitis	Yes	No	Lung trouble	Yes	No
CHF	Yes	No	Lupus	Yes	No
COPD	Yes	No	Migraines	Yes	No
Dementia	Yes	No	Neuropathy	Yes	No
Depression	Yes	No	Osteoporosis	Yes	No
Diabetes Type 1 or 2	Yes	No	Parkinson's Disease	Yes	No
Tuberculosis	Yes	No	Schizophrenia	Yes	No
Epilepsy	Yes	No	Sleep Apnea	Yes	No
Fibromyalgia	Yes	No	Stroke	Yes	No

Other Medical conditions that are not listed above: ______________________________

____

____

Do you currently smoke or use smokeless tobacco? ______ How often? ____________

Have you ever smoked or used smokeless tobacco? _____ When did you quit? ______

Do you drink alcohol? ______ How often? ______________________________________

Illicit drug use? ____

Do you exercise? If yes, what type of exercise do you do? _______________________

____

Emergency Contact & Release to Discuss Medical Information

I, ____ give Dr. Bradley Nelson D.P.M. or any person representing him permission to give medical information regarding my hospital or medical office records, lab results, x-ray results, etc. to the following person:

Name ____

Relationship __________________________ Phone _________________________

Name ____

Relationship __________________________ Phone _________________________

Name ____

Relationship __________________________ Phone _________________________

Name ____

Relationship __________________________ Phone _________________________

Please Note:

Any person not listed above on this contact form signed by you WILL NOT be able to obtain any information from Dr. Nelson or any persons representing him. If you are 18 years of age or older and living at home, we must have a signed consent form from you before Dr. Nelson can discuss any medical information about you with your parents.

_______________________________________ _________________________

Patient or Parent (Guardian) Signature Date

Acknowledgment of receipt of notice of Privacy Practice

The notice of Privacy Practices described how the Foot & Ankle Clinic of Western Oklahoma and the individual members of its professional staff may use and disclose your medical information and how you can get access to this information. Please review it carefully. If you have any questions about the notice, please contact DHHS at 200 Independence Ave, S.W. Washington, D.C. 20201, HHS.MAIL.GOV

Acknowledgment of notice of privacy practices:

A complete copy of the facility's notice of privacy practices is posted in the facility.

By signing below, you acknowledge that you have viewed a copy of the facility's notice of privacy practices.

____ ____________________

Signature of Patient Date

If the patient is a minor or is incompetent: I hereby acknowledge that I have viewed a copy of the facility's notice of privacy practices on behalf of the patient.

____ ____________________

Signature of person authorized to consent for patient Date

____

Relationship to Patient