Welcome To Our Office

PLEASE PRINT

Patient's Name: _____ Sex: M F
First Middle Last

Social Security Number: _____ Birthdate: _____

Home Address: _____ APT # _____

City: _____ State: _____ Zip: _____

Home Phone: (____) _____ Cell Phone: (____) _____

Work Phone: (____) _____

Email Address: _____

Primary Pharmacy: _____

Address _____

City: _____ State _____ Zip: _____

Telephone: (____) _____

Your Primary Language _____ Race: _____ Ethnicity : _____

How did you learn about our office? _____

Marital Status: Single ☐ Married ☐ Divorced ☐ Partner ☐ Widow(er) ☐
Student Status: Not a Student ☐ Full Time ☐ Part Time ☐
Employment Status: Full Time ☐ Part Time ☐ Not Employed ☐

Employer: _____
Employer's Address: _____
City: _____ State _____ Zip: _____

Occupation: _____

Primary Care Doctor: _____

Address: _____ City: _____ State ____ Zip: _____

Telephone: (____) _____ Date of last visit: _____

In Case of Emergency, contact: _____

Relationship _____ Home Telephone: (____) _____

I hereby give permission to have my feet examined and treated medically, surgically, or orthopedically. I clearl understand and agree that all services rendered to me are charged directly to me and that I am personally responsibl for payment.

_____
Signature Date

TRAK-NET 3-0 – SOCIAL HISTORY

Name_____

Marital Status: SINGLE MARRIED DIVORCED WIDOWED SEPARATED

Who do you live with:
NOT KNOWN HUSBAND WIFE ALONE CHILDREN SIGNIFICANT OTHER PARENTS

How many Children: _____

Employment: EMPLOYED UNEMPLOYED DISABLED RETIRED

Occupation (current or former): _____

Smoking: CURRENT SMOKER NON-SMOKER FORMER SMOKER

How much do you smoke per day?
NONE <5 PER DAY ½ PACK PER DAY 1 PACK PER DAY > 1 PACK PER DAY

Do you drink caffeinated beverages (cola, coffee, or tea)? YES NO

Number per day? _____

Medical History

Patient's Name: _____ Today's Date: _____
First Middle Last

Please answer these questions to the best of your ability

Are you in good general health?	☐ Yes	☐ No
Have you had a physical examination within 2 years?	☐ Yes	☐ No
Have you been hospitalized in the last 2 years?	☐ Yes	☐ No
Females: Are you pregnant or nursing?	☐ Yes	☐ No
Do you smoke?	☐ Yes	☐ No
Amount: _____		
Do you drink alcohol?	☐ Yes	☐ No
Amount: _____		
Does anyone in you immediate family have DIABETES, ARTHRITIS, or HEART DISEASE?	☐ Yes	☐ No

List your current medications: _____

_____

_____

Do you take any non-prescription medication? _____

_____

Are you allergic to any medications?

( ) I am **NOT** allergic to any medication to my knowledge

( ) I am allergic to:

☐ Penicillin ☐ Aspirin ☐ Codeine ☐ Cortisone ☐ Sulfa
☐ Novocain ☐ Demerol ☐ Iodine ☐ Ibuprofen ☐ Darvon
☐ Others _____

I have or had the following:

☐ Diabetes ☐ Asthma ☐ Anemia ☐ Auto Immune Deficiency
☐ Epilepsy ☐ Gout ☐ Heart trouble ☐ High Blood Pressure
☐ Stroke ☐ Ulcer ☐ Cancer ☐ Rheumatism/Arthritis
☐ Glaucoma ☐ Hepatitis ☐ Osteoporosis ☐ Kidney trouble

Have you seen a Podiatrist before? ☐ Yes ☐ No

When was your last visit? _____

Reason for today's visit? _____

_____

When did the problem start? _____

Insurance Information

Patient's Name:_____
First Middle Last

1. Was your illness related to work? ☐ YES ☐ NO
2. Was your illness based on an accident? ☐ YES ☐ NO

[Primary Insurance]

Name of Insurance:_____
Policy/ID#_____ Group#:_____
Effective Date of Coverage:_____

Insured's Name_____ Relationship_____
☐ Same Address
☐ Different Address:_____
City:_____ State:_____ Zip:_____
Home Phone:_____ Alternate Phone:_____
Birth Date:_____ Social Security Number:_____
Employer:_____

[Secondary Insurance]

☐ I am not covered by any other insurance
Name of Insurance:_____
Policy/ID#_____ Group#:_____
Effective Date of Coverage:_____

Insured's Name_____ Relationship_____
☐ Same Address
☐ Different Address:_____
City:_____ State:_____ Zip:_____
Home Phone:_____ Alternate Phone:_____
Birth Date:_____ Social Security Number:_____
Employer:_____

Please remember you are responsible for all fees, regardless of insurance coverage.

ASSIGNMENT AND RELEASE: I hereby authorize my insurance benefits to paid directly to Dr. Scott Zimmerman and I am financially responsible for all fees, regardless of insurance coverage. I authorize the release of any medical information required to process this claim.

_____
Signature Date

SCOTT A. ZIMMERMAN, D.P.M. LTD.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You may refuse to sign this acknowledgement.

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ('HIPPA'), I have certain rights to privacy regarding my protected health information. I understand that this information can be used to:

- Conduct, plan & direct my treatment and follow-up amongst the multiple health care providers who may be involved in my treatment directly or indirectly.
- Obtain payment from third-party payers
- Conduct normal health care operation such as quality assessment and physician certifications.

I have received, read and understood your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information and that I may contact this organization at any time to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or health care operation. I understand that you are not required to agree to my restriction, but if you agree then you are bound to abide by such restrictions.

PATIENT NAME: _____

PARENT OR AUTHORIZED REPRESENTATIOVE_____

SIGNATURE_____DATE_____

REQUEST FOR CONFIDENTIAL COMMUNICATION

Written Communication: ☐ Use my home address

☐ Address to: _____

_____

_____

Oral Communication: What telephone number do you prefer we use to contact you?

(_____)_____ ☐ Home ☐ Cell ☐ Work

I do not want a reminder message left at all _____ (Initials)

I do not want a postcard sent at all. _____ (Initials)

May we speak to another individual about your health? Yes ☐ No ☐

Name: _____Relationship:_____

OFFICIAL USE ONLY

I attempted to obtain the patient's signature in acknowledgement of Notice of Privacy Practices but was unable:

DATE: _____ Reason: _____Initials:_____