**Petoskey Foot Specialists**
**Dr. Patrick Richmond, D.P.M**
**Petoskey Phone- 231-347-3440**

Dear Patient,

Thank you for choosing our practice to take care of your podiatric needs.

Please fill out **ALL** of the enclosed Patient Information and Health Questionnaire forms, also please be sure to sign & date all highlighted areas.

Please arrive **15 minutes** prior to your scheduled time, bring your insurance and photo ID card or cards with you, and a list of all your medications.

If you have any questions, please call us at the above telephone number or, if it is long distance for you, call 1-800-453-5750.

You have an appointment on _____ at _____.

____ Petoskey Foot Specialists, 3890 Charlevoix Ave., Suite 110 Petoskey, MI 49770, just past Bay Harbor Traffic Light on the right coming from Petoskey.

____Mackinac Straits Foot Specialists 1140 N. State St. Saint Ignace, MI 49781

____Cheboygan Clinic, 810 S. Main St., Suite 2, Cheboygan, MI 49721

*Please be advised that if you qualify for a Sault Tribe, Little Traverse Bay Band of Odawa Indians or Bay Mills voucher/purchase order that it is **your** responsibility to request that prior to your appointment by contacting your respective contract health representative. If they give you a voucher/purchase order number please bring that as well. *

Thank You

# Patrick D Richmond DPM PC

## *Patient Information*

Last Name: _____ First Name: _____ MI _____

DOB: ____/____/____ AGE: _____ SS# _____-____-_____

Marital Status: S/M/D/W SEX: _____ Student: Y / N

Mailing Address: _____ Apt. # _____

City: _____ State: _____ Zip Code: _____

Email address: _____ Preferred Pharmacy_____

Home Phone: (____) _____-_____ cell: (____) _____-_____ work: (____) _____-_____

Emergency contact: _____ Ext:_____

Relationship: _____ Phone number:(____) _____-_____

Patients place of employment_____

How were you referred to our office?: _____

PRIMARY CARE PHYSICIAN: _____ phone: (____) _____-_____

Any Specialty Physicians being seen:

Name: _____ phone :(____) _____-_____

Condition treated: _____

Name: _____ phone :(____) _____-_____

Condition treated: _____

Name: _____ phone :(____) _____-_____

Condition treated: _____

POLICY HOLDER NAME: _____ POLICY HOLDER DOB: ____/____/_____

*SIGNATURE AND RELEASE OF INFORMATION*

I hereby authorize

(1) Treatment of the person named above and agrees to pay all fees and charges for such treatment;

(2) Any insurance benefits are to be payable directly to this office;

(3) Release of any information which may be required to process insurance claims. I am financially responsible for any deductible, co-pays, co-insurance or non-covered services remaining after insurance payments(s). If an insurance claim is denied, I am ultimately responsible for the total charges incurred.

Signature: _____ Date: ____ / ____ / _____

Patient name: _____ DOB: _____ / _____ / _____

Are you diabetic? Y / N

IF YES: Type 1 / Type 2 / Controlled / Uncontrolled

Height: _____ Weight: _____

Shoe size: _____

Please check all that apply:

___ Do you need to be PRE-medicated before surgery?

___ AIDS / HIV
___ Anemia
___ Angina
___ Arthritis
___ Asthma
___ Bleeding/Clotting Disorders
___ Cancer
___ Chemical Dependency
___ Chest Pain
___ Circulatory Problems
___ Cramps/numbness in feet or legs
___ Epilepsy
___ Fainting
___ Gout
___ Headaches
___ Heart Disease
___ Hemophilia
___ Hepatitis
___ High Blood Pressure
___ High Cholesterol
___ Joint Replacement
___ Kidney Problems
___ Low Blood Pressure
___ MRSA
___ Nervous Problems
___ Phlebitis
___ Psychiatric Care
___ Rash
___ Reynaud's Disease
___ Respiratory Disease
___ Rheumatic Fever
___ Shortness of Breath
___ Sinus Problems
___ STD
___ Stroke
___ Swelling: Ankles / Foot
___ Tuberculosis
___ Ulcers
___ Varicose Veins
___ Weight Loss
___ None of the Above

Other: _____

MEDICATIONS: Please list any prescription and over the counter medications you are taking.

| Name of Medication | Dose | x's / day | Name of Medication | Dose | x's /day |
|---|---|---|---|---|---|
| _____ | _____ | _____ | _____ | _____ | ____ |
| _____ | _____ | _____ | _____ | _____ | ____ |
| _____ | _____ | _____ | _____ | _____ | ____ |

ALLERGIES

___ **No Known Drug Allergies**
___ Aspirin
___ Codeine
___ Egg
___ Iodine
___ IV Dye
___ Latex
___ Local Anesthetic
___ Penicillin
___ Seafood
___ Sulfa
___ Tape/Adhesive
___ Other: _____

*Social History*:

___ Alcohol
___ Smoke (packs /day) _____
___ NEVER SMOKED
___ Recreational drugs
(Number of years) _____

*Family History*:

___ Anemia
___ Diabetes
___ Cancer
___ Heart Disease
___ Hypertension
___ Stroke

*Surgical History*: please list date and procedure

| Date | Procedure | Date | Procedure |
|---|---|---|---|
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |

Patient name: _____ DOB: ____/____/_____

Please describe the condition(s) that brought you in today:

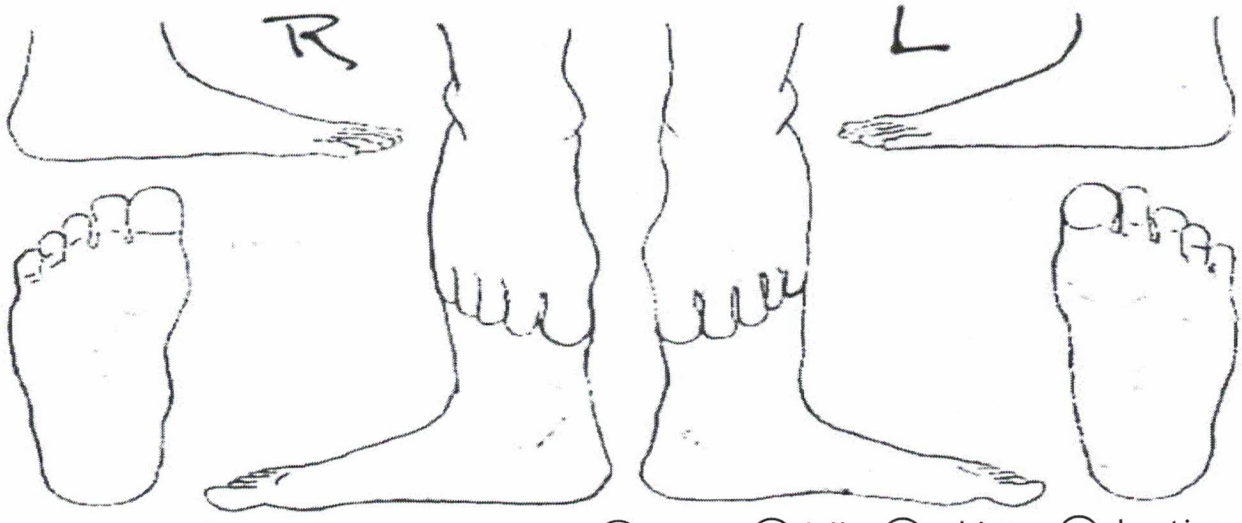
_____

_____

_____

#1 concern_____ #2 concern _____ #3 concern_____

Locate the areas of your concern




Is the discomfort: ◯burning ◯throbbing ◯sharp ◯dull ◯aching ◯shooting

The severity of discomfort/pain of your main problem: (please circle one)

RATING AT ITS WORST

Mild 1 2 3 4 5 6 7 8 9 10 unbearable

When did your problem begin? _____days _____months _____years

ONSET: ____gradual _____sudden

EXPLAIN_____

Is the problem getting worse, better, or staying the same? WORSE BETTER SAME

What seems to affect the problem? _____

When is it better? _____

When is it worse? _____

Have you had this treated before?

◯ Not treated

◯ Another Dr. treated it who, when, and how?) _____

_____

◯ **I treated it at home** (how?) _____

# NOTICE OF PRIVACY

The Department of Health and Human Services has established a "Privacy Rule" to help ensure that personal health care information is protected for privacy. The Privacy Rule provides standards for health care providers to follow when disclosing health information about the patient that is needed to carry out treatment, payment, or health care operations.

As our patient, we want you to know that we respect the privacy of your personal medical records and will do all we can to secure and protect that privacy. We strive to always take reasonable precautions to protect your privacy. When it is appropriate and necessary, we provide the minimum necessary information to only those we feel are in need of your health care information. We want to provide health care that is in your best interest.

We also want you to know that we support your full access to your personal medical records. You may request restrictions pertaining to parties to whom you do not want PHI released. You will be asked to authorize release of PHI to any party that is not directly connected to your treatment, payment, or health care operation.

If you have any questions, comments, or objections to the privacy policies on this form, please ask to speak with our HIPPA Compliance Officer. You have the right to review our entire NOTICE OF PRIVACY POLICIES upon request.

Please sign this form to acknowledge that you have read this notice of our privacy policies.

PATIENT NAME (please print): _____

SIGNATURE: _____ Date: ____ / ____ / _____

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Thank you for choosing our practice for your podiatric needs.
Following is our Payment Policy. Please read carefully and sign and date.

# PAYMENT POLICY

We accept most major insurance plans. We require deductibles, coinsurance and co-pays and other office charges not covered by insurance or in the absence of insurance to be paid in full at the time of service. If you have any questions concerning what charges you may incur, please feel free to call in advance and we will try to estimate what the charges might be. If there are any differences in the charges collected and the actual charges billed, the patient is responsible for the difference. We accept most major credit cards.

**I have read and understand the above Payment Policy.**

Patient Name (please print): _____

Signature of patient / Responsibility party: _____