McDERMOTT PODIATRY
Michael McDermott, DPM, FACFAS

NAME: _____ **AGE:**_____ **MALE( ) FEMALE( )**

ADDRESS: _____
STREET

_____
CITY *STATE* *ZIP CODE*

EMAIL: _____

HOME PHONE: _____ **WORK PHONE**_____

CELL PHONE: _____

DATE OF BIRTH: _____ **SOCIAL SECURITY:**_____

ETHNICITY: (_) Hispanic or Latino (_) Not Hispanic or Latino (_) Decline

RACE: (_) American Indian or Alaska Native (_) Asian
(_) Black or African American (_) Native Hawaiian or Other Pacific Islander
(_) White (_) Other (_) Decline

EMERGENCY CONTACT: _____ **PHONE:** _____

MARITAL STATUS: (_) Married (_) Single (_) Widowed (_) Divorced

Primary Care Physician: _____

Phone Number: _____ ***Last Seen:*** _____

REFERRED BY: _____ **LAST SEEN:** _____

PODIATRIST: _____ **LAST SEEN:** _____

INSURANCE COVERAGE: Please present insurance card(s) to receptionist.

I authorize the release of any medical or other information necessary to process this claim.

Date: _____ **Signature:** _____

I authorize direct payment of medical benefits to McDermott Podiatry for services rendered. I understand I am responsible for any amount not covered by my insurance. I also understand I will be responsible for any other charges incurred by McDermott Podiatry for collection of overdue payment.

Date: _____ **Signature:** _____

I hereby give permission to the doctor to administer treatment and perform such general procedures as he may deem necessary in the diagnosis and/or treatment of my foot condition.

Date: _____ **Signature:** _____

PATIENT CONSENT FORM

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

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly
- Obtain payment from third-party payers
- Conduct normal healthcare operations such as quality assessments and physician certifications

I have been informed by you and your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such *Notice of Privacy Practices* prior to signing this consent. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address below 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 threatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you agree then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Signature: _____

Patient Name: _____

Relationship to Patient: _____

Date: _____

PERSONAL HISTORY AND PODIATRIC PHYSICAL

DATE: _____

NAME: _____

DATE OF BIRTH: _____

REASON FOR VISIT: _____

MEDICAL STATUS: Please check any that apply.

Diabetes *How long?*	High Blood Pressure	Heart Trouble	Broken Bones
Prolonged Bleeding	Circulation Disease	Arthritis	Varicose Veins
Cancer	Anemia	Tuberculosis	Blood Disease
Asthma	Kidney Trouble	Polio	Rheumatic Fever
Stomach Ulcers	Liver Trouble	Skin Cancer	
Other:			

ALLERGIES: Please check any that apply.

Latex	Penicillin	Tape	Novocain
Food	Environmental	IV Dye	
Other:			

Have you ever used tobacco? Yes__ No__ If yes, daily amount: _____

Do you drink alcoholic beverages? Yes__ No__ If yes, weekly amount: _____

Current Medications: If you have a list, please give to receptionist to photocopy.

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

Surgical History: If you have a list, please give to receptionist to photocopy.

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____