NE IOWA PODIATRY, PC

Today's Date

First Name: _____ MI: _____ Last Name: _____

Gender: Male ___ Female ____ SSN: ____-____-____ Birthdate: ____/____/____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Would like to accept text message reminders? ☐YES ☐NO

E-mail: _____ Best Time To Reach You? _____

Name of Emergency Contact: _____ Relationship:_____

Emergency Contact Phone: _____

Preferred Language:_____

Race ☐ White ☐ Black / African American ☐ American Indian / Alaska Native ☐ Asian
☐ Native Hawaiian / Other Pacific Islander ☐ Not Specified

Ethnicity ☐ Not Hispanic / Latino ☐ Hispanic / Latino

Marital Status: S M W D Are you a student?: yes no Are you employed ?: yes no

Place of Employment: _____

Primary Care Physician: _____ **Date Last Seen:** ____/____/____

Referring Doctor: _____

Primary Insurance: _____ Secondary Insurance: _____

Policy Holder Name: _____ Policy Holder Name: _____

Relationship to Patient: _____ Relationship to Patient: _____

Policy Holder Date of Birth: ____/____/____ Policy Holder Date of Birth: ____/____/____

NE IOWA PODIATRY, PC

Podiatric History

Name: _____ DOB: _____ Today's Date: _____

Current Foot/Ankle Problems: _____ Left Right Both (Circle)

How long has this been bother you? ____Days ____Weeks ____Months____Years

Is this due to an injury □Yes □No Work or Sports Related? □Yes □No

Any Former Imaging? □Yes □No Circle One: If yes, Where: _____

Are you Allergic to any of the following?

Adhesive Tape	☐ Yes ☐ No	Iodine	☐ Yes ☐ No	Novacaine/Lidocaine	☐ Yes ☐ No
Aspirin	☐ Yes ☐ No	Ibuprofen	☐ Yes ☐ No	Penicillin	☐ Yes ☐ No
Codeine	☐ Yes ☐ No	Latex	☐ Yes ☐ No	Seafood	☐ Yes ☐ No
Contrast Dye	☐ Yes ☐ No	Neosporin	☐ Yes ☐ No	Sulfa	☐ Yes ☐ No

Please List Any Others: _____

Any Family History (Blood Relative) Of:

Diabetes ☐ Yes ☐ No Who? _____ Heart Conditions ☐ Yes ☐ No Who? _____

Cancer ☐ Yes ☐ No Who? _____ Foot Problems ☐ Yes ☐ No Who? _____

Arthritis ☐ Yes ☐ No Who? _____ Blood Clots ☐ Yes ☐ No Who? _____

Medications

Do you give consent for us to obtain your prescription history? ☐ Yes ☐ No

If No, Please list any medications you are currently taking.

_____

_____

_____

_____

_____

Pharmacy Name: _____ Pharmacy Location: _____

NE IOWA PODIATRY, PC

Podiatric History

Name: _____ DOB: _____ Today's Date: _____

Have you EVER been treated for the following?

AIDS/HIV	☐ Yes ☐ No	Eye Problems	☐ Yes ☐ No
Anemia	☐ Yes ☐ No	Gout	☐ Yes ☐ No
Arthritis	☐ Yes ☐ No	Heart Disease/Attack	☐ Yes ☐ No
Asthma	☐ Yes ☐ No	Hepatitis	☐ Yes ☐ No
Autoimmune	☐ Yes ☐ No	High Blood Pressure	☐ Yes ☐ No
Back Problems	☐ Yes ☐ No	Kidney Disease	☐ Yes ☐ No
Blood Clots	☐ Yes ☐ No	Liver Disease	☐ Yes ☐ No
Cancer	☐ Yes ☐ No	Lung Disease	☐ Yes ☐ No
CHF	☐ Yes ☐ No	Migraines	☐ Yes ☐ No
COPD	☐ Yes ☐ No	Rheumatoid Arthritis	☐ Yes ☐ No
Depression	☐ Yes ☐ No	Seizures	☐ Yes ☐ No
Diabetes	☐ Yes ☐ No	Stroke	☐ Yes ☐ No
Dermatitis	☐ Yes ☐ No	Thyroid Disease	☐ Yes ☐ No
Ear Problems	☐ Yes ☐ No	Vascular Disease	☐ Yes ☐ No

If Diabetic, Last A1C: _____ What physician do you see for your diabetes? _____

List ANY SURGERIES:

_____

_____

_____

Do you drink Alcohol? ☐ Yes ☐ No

Do you currently Smoke Cigarettes? ☐ Yes ☐ No Do you Vape? ☐ Yes ☐ No

Are you a former Smoker? ☐ Yes ☐ No

Have you had your flu shot for the current season?
☐ Yes ☐ No

If No, Why? (Circle One) Allergy Declined Vaccine Unavailable

For Patients 65 and Older
Have you had your current pneumonia vaccine? ☐ Yes ☐ No

Do you have a living will? ☐ Yes ☐ No

To Be Completed By The Nurse

Height: _____

Weight: _____

Pulse: _____

Respirations: _____

Blood Pressure: _____/_____

Patient Name (please print) _____ Date _____

ASSIGNMENT AND RELEASE

- I hereby give Dr. Stephen Meyer, Dr. Colleen Lowe and associates permission to diagnose and treat my foot condition.
- I also authorize this office to release medical information to insurance carriers necessary in securing payment of benefits. I authorize the use of this signature on all insurance submissions. I understand that I am responsible for giving "Northeast Iowa Podiatry, PC" the correct insurance information at the time services are rendered. Northeast Iowa Podiatry, PC agrees to bill your insurance carrier(s). All insurance information must be provided to our office, at the time of service.
- I understand that I am responsible for obtaining the proper referral and may be held responsible for charges not covered by my Insurance due to my failure to obtain the required referral.
- I agree to pay for non-covered services under my insurance plan (services for which I have a policy exclusion). I understand that I am responsible for all balances not paid by my insurance carrier, including deductibles, co-pay, and co-insurance and out of network penalties.
- I understand that Northeast Iowa Podiatry, PC is not responsible for knowing if the group/physician is a participating provider with my insurance carrier.

Signature of Responsible Party _____

Name of Responsible Party (If different from the patient) _____

Address (If different from patient) _____

Acknowledgement of Receipt of Notice of Privacy Practices

I acknowledge that I was provided a copy of the Notice of Privacy practices and that I have read (or had the opportunity to read if I so chose) and understand the Notice.

_____
Signature of patient or
Parent or Authorized Representative (if applicable)

I currently decline a hard copy of the Notice of Privacy Practice: Please Initial:_____

Medicare Part B Signature Authorization

I authorize any holder of medical or other information about me to release to Social Security Administration and Health Care Financing Administration or its intermediaries or carriers, or to the billing agent of this physician or supplier any information needed for this or a related Medicare Claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment.

I UNDERSTAND THAT THIS IS A LIFETIME SIGNATURE AUTHORIZATION.

_____
Signature

NORTHEAST IOWA PODIATRY, PC
44 Brookeridge Drive
Waterloo, IA 50701

SUMMARY OF NOTICE OF PRIVACY PRACTICES

This summary is provided to assist you in understanding the attached Notice of Privacy Practices

The attached Notice of Privacy Practices contains a detailed description of how our office will protect your health information, your rights as a patient and our common practices in dealing with patient health information. Please refer to the Notice for further information.

Uses and Disclosures of Health Information We will use and disclose your health information in order to treat you or to assist other health care providers in treating you. We will also use and disclose your health information in order to obtain payment for our services or to allow insurance companies to process insurance claims for services rendered to you by us or other health care providers. Finally, we may disclose your health information for certain limited operational activities such as quality assessment, licensing, accreditation and training of students.

Uses and Disclosure Based on Your Authorization Except as stated in more detail in the Notice of Privacy Practices, we will not use or disclose your health information without your written authorization.

Uses and Disclosures Not Requiring Your Authorization In the following circumstances, we may disclose your health information without your written authorization:

- To family members or close friends who are involved in your health care;
- For certain limited research purposes;
- For purposes of public health and safety;
- To Government agencies for purposes of their audits, investigations and other oversight activities;
- To government authorities to prevent child abuse or domestic violence;
- To the FDA to report product defects or incidents;
- To law enforcement authorities to protect public safety or to assist in apprehending criminal offenders;
- When required by court orders, search warrants, subpoenas and as otherwise required by the law.

Patient Rights As our patient, you have the following rights;

- To have access to and/or copy of your health information;
- To receive an accounting of certain disclosures we have made of your health information;
- To request restrictions as to how your health information is used or disclosed;
- To request that we communicate with you in confidence;
- To request that we amend your health information;
- To receive notice of our privacy practices.

If you have a question, concern or complaint regarding our privacy practices, please refer to the attached Notice of Privacy Practices for the person or persons whom you may contact.