FEET FIRST, PLLC/C. LYNN ROSENBAUM, D.P.M **NEW PATIENT FORMS**

PATIENT INFORMATION

Name: _____ DOB: _____ Age: _____ Sex: M ☐ F ☐ SS#: _____

Address: _____ City: _____ State: _____ Zip: _____

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

May we call the phone #'s provided above and/or leave a voicemail? Yes No May we send you text messages? Yes No

May we send you emails? Yes No Email: _____
With whom may we speak with regarding your medical information: _____

Emergency Contact Name: _____ Relationship: _____ Phone#: _____

Pharmacy Name: _____Pharmacy Phone: _____

Primary Care Doctor: _____Phone #: _____ Last Date Seen: _____

INSURED INFORMATION

Primary Insurance: _____ Are you the insured? ☐ Yes ☐ No

Subscriber Name: _____Relationship to the insured: ☐ Spouse ☐ Child ☐ Self ☐ Other

Sex: ☐ Male ☐ Female DOB: ____/____/____ Policy ID: _____Group ID: _____

Secondary Insurance: _____ Are you the insured? ☐ Yes ☐ No

Subscriber Name: _____Relationship to the insured: ☐ Spouse ☐ Child ☐ Self ☐ Other

Sex: ☐ Male ☐ Female DOB: ____/____/____ Policy ID: _____Group ID: _____

SOCIAL HISTORY

Marital Status: ☐ Single ☐ Married ☐ Partnered ☐ Separated ☐ Divorced ☐ Widowed

Use of Alcohol: ☐ Never ☐ No Longer Use ☐ History of Alcohol Abuse

Current Use - Type: _____ ☐ Rare ☐Occasional ☐ Moderate ☐ Daily

Use of Tobacco: ☐ Never ☐ Quit – How long ago? _____ Type: _____

Smoke: (Circle One) < 5 cigarettes per day ½ pack per day 1 pack per day > 1 pack per day For how many years: _____

Use of Recreational Drugs: ☐ Never ☐ Quit – How long ago? _____ Type: _____

Current Use - Type: _____ ☐ Rare ☐Occasional ☐ Moderate ☐ Daily

Employer: _____ Occupation: _____

How much are you on your feet at work? ☐ 10% ☐ 25% ☐ 50% ☐ 75% ☐ 100%

Do others depend on your care? ☐ Children – Age(s): _____ ☐ Pet(s) – What Kind? _____

☐ Elderly or Disabled Family Member ☐ Other: _____

Exercise: ☐ Never ☐ Rare ☐ Occasional ☐ Weekly ☐ Several Times Per Week ☐ Daily

Types of Exercise: _____

FAMILY HISTORY

Do you have a family history of: ☐ Diabetes Type 1 or 2 ☐ Cancer ☐ Heart Disease ☐ High Blood Pressure

☐ Stroke ☐ Coronary Artery Disease ☐Thyroid Disease ☐ Rheumatoid Arthritis ☐ Other: _____

MEDICAL HISTORY

Allergic to: (Circle) Penicillin Sulfa Drugs Codeine Morphine NSAIDS Aspirin Iodine
Adhesive Tapes Latex Steroids Shellfish General or Local Anesthetics
Other: _____

Please list all medications you are currently taking: (Including prescriptions, over-the-counter vitamins/herbal supplements)

Name of Medication	Dosage (MG)	How often do you take?

Prior Surgeries:

Type of Surgery	Date	Type of Surgery	Date

Height: _____ Weight: _____ Shoe Size: _____ Shoe Type: _____

Have you ever received a COVID-19 vaccine? Yes No If yes, dates administered: _____

Have you ever received a Flu Vaccine? Yes No If yes, date administered: _____

Review of Systems (circle all that apply)

MAJOR ILLNESS: Diabetes Type 1 or 2 / Heart Disease / Hypertension / Chest Pain Angina / Heart Attack / Cancer / Mitral Valve Prolapse / Murmur / Arrhythmia / Congestive Heart Failure / Pacemaker

RESPIRATORY: Asthma / Bronchitis / Emphysema / Frequent Colds / Shortness of Breath / COPD / Lung Disease or Breathing Problems / Tuberculosis / Smoker

EENT: Sinus Problems or Infections / Tonsillitis / Throat Infections / Glaucoma / Cataracts / Eye or Vision Problems / Headaches / Migraines / Ear Infections / Hearing Deficit

GASTROINTESTINAL: Ulcers / Reflux / Hiatal Hernia / Stomach Disorder / Bowel Disorder / Irritable Bowel Syndrome / Hemorrhoids / GI or Rectal Bleeding / Rectal Fissures

GENITOURINARY: Kidney or Bladder Infections / Kidney Stones / Decreased Kidney Function / Prostate / STD

VASCULAR DISEASE / BLOOD DISORDERS: Poor Circulation / PVD / Leg or Calf Pain / Night Cramps / Rest Pain / Vein Problems / Swelling / Spider Veins / Varicose Veins / Phlebitis / Leg Ulcers / Blood Clots / Deep Vein Thrombosis / Pulmonary Embolism / Bleeding or Clotting Disorders / Easy Bruising / Anemia / Sickle Cell / Transfusions

MSK / NEURO: Back Pain / Joint Pain / Joint Stiffness / Joint Swelling / Cold Feet / Leg Cramps / Burning Feet / Numb Feet / Tingling Feet

ARTHRITIS: Rheumatoid / Osteo / Gout / Other: _____

SKIN DISORDERS: Psoriasis / Skin Cancer / Dry Skin / Painful Scars / Nail Abnormalities / Ulcers on Feet or Legs

PSYCHOLOGICAL: Anxiety / Depression / Psychiatric Disorder / Drug or Alcohol Dependency

MISC: Epilepsy or Seizures / Thyroid Disease / Muscle Disease / Tremors / Hepatitis / HIV or AIDS / Lyme Disease / Pregnancy / Breast Feeding

*If you are a diabetic, please list your last Hemoglobin A1C: _____% Date Performed: _____

CURRENT PROBLEM

What specific problem brings you to the office today? _____

Which Foot? _____ Is one side worse than the other? Y N If yes, which side? _____

How long ago did this problem start? _____ Days / Weeks / Months / Years

Did your pain or problem: ☐ Begin all of a sudden ☐ Gradually develop over time

How would you describe your pain? ☐ No Pain ☐ Sharp ☐ Dull ☐ Aching ☐ Burning ☐ Radiating ☐ Itching ☐ Stabbing

How would you rate your pain on a scale of 0 to 10? (Please Circle)

(No Pain) 0 1 2 3 4 5 6 7 8 9 10 (Worst Pain Possible)

Since the time your pain or problem began, has it? ☐ Stayed the Same ☐ Become Worse ☐ Improved

What makes your pain or problem feel worse? ☐ Walking ☐ Standing ☐ Daily Activities ☐ Resting ☐ Dress Shoes

☐ High Heels ☐ Flat Shoes ☐ Any Closed Toe Shoes ☐ Running ☐ Other: _____

What makes your pain better? _____

What treatment have you had for this problem? _____

How has this problem affected your lifestyle or ability to work? _____

Was this problem caused by an injury? ☐ Yes (Describe) _____ ☐ No

If yes, was it a work-related injury? ☐ Yes ☐ No

DEPRESSION SCREENING: (AGES 12 AND UP)

Have you ever been diagnosed with depression or currently taking medication for it? Yes No

If the answer is no, how often have you been bothered by the following over the past 2 weeks? (Please Circle)

	0	1	2	3
Little interest of pleasure in doing things?	Not at all	Several days	More than half the days	Nearly every day
Feeling down, depressed or hopeless?	Not at all	Several days	More than half the days	Nearly every day
Trouble falling or staying asleep or sleeping too much?	Not at all	Several days	More than half the days	Nearly every day
Feeling tired or having little energy?	Not at all	Several days	More than half the days	Nearly every day
Poor appetite or overeating?	Not at all	Several days	More than half the days	Nearly every day
Feeling bad about yourself or that you are a failure?	Not at all	Several days	More than half the days	Nearly every day
Trouble concentrating on things such as reading or tv?	Not at all	Several days	More than half the days	Nearly every day
Fidgety or restless / moving a lot more than usual?	Not at all	Several days	More than half the days	Nearly every day
Thought of hurting yourself in some way?	Not at all	Several days	More than half the days	Nearly every day

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Ages 18 and up – Do you smoke? Yes No If yes, circle one of the following: < 5 cigarettes per day ½ pack per day
1 pack per day > 1 pack per day

Ages 65 and up – Have you ever received a pneumonia vaccine? Yes No Year Administered: _____

Ages 65 and up – Have you had a fall in the past year with an injury? Yes No
Have you had two or more falls in the past year? Yes No

Do you use any of the following to assist with walking? Cane Walker Wheelchair Crutches None

DO NOT WRITE BELOW THIS LINE – FOR OFFICE USE*****************************

MIPS: Ages 18 and Up – Diabetic? Yes No If yes, Last A1C: _____% On Date: _____

Ages 12 and Up-Depression Screening Taken Above? Yes No Score: _____

Ages 18 and Up–Hypertension (Over 119/79) If yes, was paper given to take to PCP? Yes No

Ages 18 and Up - Tobacco Use: Yes No If yes, was paper given for encouragement to quit? Yes No

Ages 65 and Up – Ever received a Pneumonia Vaccine Yes No Year Administered: _____

All Ages – Ever received an Influenza Vaccine Yes No Year Administered: _____

Ages 18 and Up – BMI _____ If greater than 25, was paper given to encourage diet / exercise? Yes No

Ages 65 and Up – Fall Risk Assessment? No Falls 1 Fall w/ Injury 2 Falls or More If yes, was paper given for fall care plan? Yes No

Ages 18 and Up – Diabetic Eye Screening? Yes No

To the best of my knowledge, I have answered the questions on this form accurately. I understand that providing incorrect information can be dangerous to my health. I understand that it is my responsibility to inform the doctor and office staff of any changes in my medical status.

_____ _____

Patient/Guardian Signature Date

Patient HIPAA Consent Form

By signing this form, you are granting consent to Feet First, PLLC to use and disclose your protected health information for the purposes of treatment, payment and health care operations. Our Notice of Privacy Practices provides more detailed information about how we may use and disclose this protected health information. You have a legal right to review our Notice of Privacy Practices before you sign this consent, and we encourage you to read it in full. Our Notice of Privacy Practices is subject to change. If we change our notice, you may obtain a copy of the revised notice by contacting us at (931) 854-9222. You have a right to request us to restrict how we use and disclose your protected health information for the purposes of treatment, payment or health care operations. We are not required by law to grant your request. However, if we do decide to grant your request, we are bound by our agreement. You have the right to revoke this consent in writing, except to the extent we already have used or disclosed your protected health information in reliance on your consent.

_____ _____

Patient/Guardian Signature Date

SURESCRIPTS CONSENT FORM

I authorize Feet First, PLLC to electronically obtain access to my prescription history from participating pharmacies through the Surescripts network. This will assist Feet First, PLLC providers with prescribing, assessing health conditions and recommending appropriate treatment.
I understand that this consent will remain in effect until I am terminated in writing as a patient of this practice or until I submit a written request to revoke this consent to the practice. However, any disclosures that occurred prior to the date of revocation will not be affected.

_____ _____

Patient/Guardian Signature Date

Revised: 1/2/2023

EMAIL / TEXT INFORMED CONSENT FORM

I understand that the information sent to me via email and/or via text message from persons at Feet First, PLLC will not be sent securely and will be unencrypted. I understand the risks associated with that including, but not limited to, that my PHI may be read by an unintended third party. I have been notified of the risks. I understand said risks and I still prefer to receive protected health information via unsecure communications via email and text message. I understand that Feet First, PLLC and its staff are not responsible for any unauthorized access of my protected health information communicated by way of unencrypted email and text and that I bear the risk.

_____ _____

Patient/Guardian Signature Date

Patient Financial Policy

Your understanding of our financial policies is an essential element of your care and treatment. If you have any questions, please discuss them with our front office staff or supervisor.

- As our patient, you are responsible for all authorizations/referrals needed to seek treatment in this office.
- Unless other arrangements have been made in advance by you, or your health insurance carrier, payment for office services are due at the time of service. We will accept Visa, MasterCard, Discover, cash or check.
- Your insurance policy is a contract between you and your insurance company. As a courtesy, we will file your insurance claim for you if you assign the benefits to the doctor. In other words, you agree to have your insurance company pay the doctor directly. If your insurance company does not pay the practice within a reasonable period, we will have to look to you for payment.
- We have made prior arrangements with certain insurers and other health plans to accept an assignment of benefits. We will bill those plans with which we have an agreement and will only require you to pay the co-pay/co-insurance/deductible.
- If you have insurance coverage with a plan with which we do not have a prior agreement, we will prepare and send the claim for you on an unassigned basis. This means your insurer will send the payment directly to you. Therefore, all charges for your care and treatment are due at the time of service.
- All health plans are not the same and do not cover the same services. In the event your health plan determines a service to be "not covered," or you do not have an authorization, you will be responsible for the complete charge. We will attempt to verify benefits for some specialized services or referrals; however, you remain responsible for charges to any service rendered. Patients are encouraged to contact their plans for clarification of benefits prior to services rendered.
- You must inform the office of all-insurance changes and authorization/referral requirements. In the event the office is not informed, you will be responsible for any charges denied.
- For most services provided in the hospital, we will bill your health plan. Any balance due is your responsibility.
- There are certain elective surgical procedures for which we require pre-payment. You will be informed in advance if your procedure is one of those. In that event, payment will be due one week prior to the surgery.
- Past due accounts if your account becomes sixty days past due, further steps will be taken to collect the debt. If the account is referred to a collection agency, you agree to pay your balance plus a $50 collection fee and any additional collection costs that are incurred. If collection of the balance of your account is turned over to a lawyer, you agree to pay all lawyer fees which are incurred plus court costs. In case of suit, you agree the venue shall be Putnam County, Tennessee. In addition, we reserve the right to deny future non-emergency treatment for any and all debtor-related unpaid account balances.
- There is a service fee of $25.00 for all returned checks. Your insurance company does not cover this fee.
- All appointments that need to be cancelled should be done 24 hours prior to the appointment. If you fail to cancel the appointment and do not come in for your appointment, you can be charged a fee of $25.00.
- There will be a charge for all medical records printed. A $20.00 fee for the first 5 pages and $0.50 per page for each page thereafter. Please allow ample time (1 week) to be completed.
- There will be a fee of $20.00 to complete disability/FMLA paperwork, per set. Please allow ample time (1 week) to be completed.
- Copies of x-rays can be made for a fee of $5.00 per disc when requested by a third party.

_____ _____

Patient/Responsible Party Signature Date