James P. Huish DPM
NEW PATIENT INFORMATION FORM

PERSONAL INFORMATION

Full Name: ____ Date: _________________

Date of Birth: ____ Gender: Male ☐ Female ☐

Race:______________________ Ethnicity:_____________________ Preferred Language:_______________________

Home Phone: (_____)_________________ Cell: (______) __________________ Work: (_____)___________________

Home Address:____City:_____________Zip:___________

Mailing Address:____City:_____________Zip:___________

Email Address: ____Preferred method of Contact: Letter ☐ Email ☐

In case of Emergency who should be notified? __________________________ Phone: (_______) __________________

ADDITIONAL INFORMATION

Primary Care Physician: ____PCP Phone: (_______)__________________

Pharmacy Name: ____City: _______________________________

Patient Employer: ____

Who may we thank for referring you? ____

INSURANCE INFORMATION

Primary Plan: ____

Secondary Plan: ____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s) have insurance coverage and assign all benefits directly to the office of James P. Huish DPM. I understand I will be responsible for any portion of the claim, which is denied or not covered by my insurance company. I authorize the release of any and all information necessary to my insurance carriers to allow this office to process my claim benefits.

RELEASE OF INFORMATION

I hereby authorize James P. Huish DPM LLC to release any medical information or incidental information to my referring physician or any other physician who have been or may become involved in my care.

Who may receive information regarding your Protected Health Information?

Name:____ Relationship: __________________

ACKNOWLEDGEMENT OF REVIEW OF NOTICE OF PRIVACY PRACTICES

I have received a copy of the Privacy Rules from this provider and authorized the above list of persons who may receive my Protected Health Information. I may revoke this at any time by giving written notification to the office of Dr. Huish.

Signed: ____ **Date:** ______________________

Patient Name: ____

FOOT & ANKLE PROBLEM QUESTIONAIRE

Which foot/ankle is causing the problem? Please mark the site of your pain/problem with an "X".

LEFT **RIGHT**

Main reason for your visit: ____

____

____

How long has this problem existed? __________ ☐ Days ☐ Weeks ☐ Months ☐ Years

Have you experienced this problem in the past? ☐ YES ☐ NO

Is the problem related to an accident, job, sport, etc.? ☐ YES ☐ NO

If yes, please describe: ____

How do you rate your pain? (No Pain) 0 1 2 3 4 5 6 7 8 9 10 (Severe Pain)

How does your problem affect your daily activities, your job, your exercise program? ______________________

____

What makes the problem worse? ____

____

What makes the problem better? ____

____

What treatments have you tried? ☐ Rest ☐ Ice/Elevation ☐ Arch Support ☐ Physical Therapy ☐ Medication: __________

☐ Other: ____

Have you seen another physician for this problem? ☐ NO ☐ YES: ______________________________

Do you have any history of foot / ankle surgery? ☐ NO ☐ YES: ______________________________

NEW PATIENT INFORMATION FORM

Patient Name: ____

Primary Care Provider: ____________________ Last Visit Date: ____________________

Do you grant permission for this office to retrieve records from your previous treating physician? ☐ YES ☐ NO

PAST OR CURRENT MEDICAL CONDITIONS

☐ Diabetes Type I or II	☐ Arthritis (Osteo)	☐ High Blood Pressure	☐ Chronic Pain
☐ Peripheral Neuropathy	☐ Arthritis (Rheumatoid)	☐ High Cholesterol	☐ Sciatica
☐ Vascular Disease	☐ AIDS/HIV	☐ Heart Disease	☐ Anxiety / Depression
☐ Leg / Foot Ulcer	☐ Asthma / COPD	☐ Kidney Disorder	☐ Anesthesia Problems
☐ DVT / Blood Clot	☐ Autoimmune Disease	☐ GI Problems (Ulcers, GERD)	☐ Addiction to Narcotics
☐ Gout	☐ Cancer	☐ Liver Disease / Hepatitis	☐ Addiction to Alcohol

Please list any other medical problems: ____

____

SURGICAL HISTORY

Please list all surgical procedures you have had: ____

____

CURRENT MEDICATIONS

____

____

____

____

____

____

____

FAMILY HISTORY

	Mother	Father	Grandparent
Anesthesia Problems	☐	☐	☐
Arthritis (Rheumatoid)	☐	☐	☐
Arthritis (Osteo)	☐	☐	☐
Cancer	☐	☐	☐
Diabetes Type I or II	☐	☐	☐
Heart Disease	☐	☐	☐
High Blood Pressure	☐	☐	☐
High Cholesterol	☐	☐	☐
Vascular Disease	☐	☐	☐

ALLERGIES

☐ **None**	☐ Latex
☐ Iodine	☐ Metals (rash or blister with jewelry)
☐ Codeine	☐ Local Anesthetics
☐ Sulfa	☐ Penicillin

Please list any other allergies:

____

SOCIAL HISTORY

Tobacco Use? ☐ Yes ☐ No How Much ____________

How Long ____________

Alcohol Use? ☐ Yes ☐ No How Often ____________

How Long ____________

Drug Use? ☐ Yes ☐ No Which drugs ____________

Pregnant? ☐ Yes ☐ No Due Date ____________

Is there anything else regarding your medical history that is important for your doctor to know?

____

____

Height: ________________ **Weight:** ________________ **Shoe Size:** ____________

PATIENT FINANCIAL RESPONSIBILITY

Patient Name: ____

I HEREBY AUTHORIZE MY INSURANCE COMPANY TO MAKE PAYMENTS DIRECTLY TO:

James P. Huish DPM LLC

I understand that I am financially responsible for any co-payments, deductibles, co-insurance, and all charges, which are not covered by my insurance. I understand that there will be a **$25.00** service charge on all returned checks. **I understand that verification of benefits is not a guarantee of payment.** (Insurance benefits are determined by your insurance company when the claim is received.) I understand that I will be responsible for any portion of the claim that is allowed by, but not covered by, my insurance company. With the exception of Medicare, I understand that if I have secondary insurance, I am responsible for payment of my co-insurance at the time service is rendered. I understand that, upon request, I will be provided with all required documentation to collect reimbursement myself.

I understand that I am responsible for all medical charges if it is determined that the insurance billing information I have provided is not accurate or current.

Delinquent accounts will be turned over to a collection agency without notice. Accounts will be considered delinquent if unpaid after 60 days. In the event my account is turned over for collection, I will pay all reasonable collection, court and attorney costs at the time the account is considered delinquent.

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Signature of Responsibility Party Printed Name of Responsibility Party Date