NEW PATIENT REGISTRATION

Dr. Dawn Miles PODIATRY

Date: _____

Last Name: _____ First Name: _____ Middle initial ____

Suffix: _____ Address: _____

City: _____ State: _____ Zip: _____

Phone: Home: _____ Work: _____ Cell: _____

Date of Birth: ____/_____/_____ Social Security: _____

(please circle)

Marital Status: Married Single Widowed Separated Divorced

Race: American Indian or Alaska Native Asian Black or African American Chinese

Decline to disclose Filipino Guamanian or Chamorro Japanese Korean

Native Hawaiian or other Pacific Islander Samoan Vietnamese White

Ethnicity: Cuban Decline to Disclose Hispanic or Latino Unknown Mexican

Mexican American Not Hispanic or Latino Puerto Rican

Primary Insurance: _____ ID or Contract #: _____

Secondary Insurance: _____ ID or Contract #: _____

Whose name is the policy in: _____

Primary DR: _____ Phone #: _____

Date of Appt. : _____ Time: _____

Social History

Dr. Dawn Miles PODIATRY

Smoking

Have you ever smoked? O Yes O No Start Date: _____ Stop Date: _____

If current or past, How many packs per day? _____ # of years? _____

Are you interested in quitting? O Yes O No

Drug Use

Do you take illegal drugs or illegal Rx medications O Yes O No

Alcohol

Do you drink alcohol? O Yes O No If yes, how many drinks on a typical day?

Allergies

____ Adhesive/ Tape	____ Local anesthetic	____ Sulfa
____ Demerol	____ Seafood	____ Codeine
____ Penicillin	____ Aspirin	____ Other (Please list below)
____ Anticoagulant	____ Novocain	____ NONE

Other Allergies: _____

Preferred Pharmacy: _____ Phone Number: (___)_____

Dr. Dawn Miles PODIATRY

SURGICAL HISTORY (Please check all that apply and list date)

- ○ Appendectomy_____
- ○ Amputation _____

  Body Part: _____
- ○ Back (Fusion/discectomy

  _____
- ○ Fracture Repair Ankle R or L

  _____
- ○ Fracture Repair Foot R or L

  _____
- ○ Gallbladder _____
- ○ Gastric bypass _____
- ○ Heart bypass _____
- ○ Hernia Repair _____
- ○ Hysterectomy _____
- ○ Intestinal _____
- ○ Joint replacement R or L

  _____
- ○ Stents-Leg _____
- ○ Stents-Cardiac _____
- ○ Tonsillectomy _____

Other surgeries and dates: _____

_____

_____

Hospitalizations other than for surgeries listed: _____

_____

_____

Are you now or have you ever been under any other doctor's care in the past two years? ○ Yes ○ NO If yes please explain: _____

_____

MEDICATION LIST

Dr. Dawn Miles PODIATRY

_____ Not currently taking any medications.

Medication Name:	**Dosage:**	**Frequency:**
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		
11.		
12.		
13.		
14.		
15.		

Pharmacy: _____ Location: _____

CURRENT MEDICATIONS:

****Please sign your name on the line below if you consent to our physicians obtaining your prescription information from your pharmacy database. Information received is for patient care only and the information retrieved will become part of your HIPAA protected chart.***

Patient Signature: _____

○ **Check here if you do NOT authorize us to obtain a list of medications from the pharmacy database.**

(***Please note: In order to protect your health from potential contraindicated medication complications, our physicians will not be able to write any prescriptions for any patient who has not given consent to obtain a full Rx medication list.)***

Dr. Dawn Miles PODIATRY

PAST OR PRESENT ILLNESSES (Circle all that apply)

- ADHD
- AIDS/HIV
- AFIB
- ALZHEIMERS
- ANEMIA
- ANEURYSAM
- ANGINA/CHEST PAIN
- ARRHYTHMIAS
- ARTHRITIS
- ARTIFICIAL JOINTS
- ARTIFICIAL VALVE
- ASTHMA
- BACK PROBLEMS
- BLEEDING DISORDERS
- BLINDNESS
- CIRCULATORY ISSUES
- CLOTTING PROBLEMS
- COPD
- CORONARY ARTERY DISEASE
- DIABETES
- DVT
- EMPHYSEMA
- EPILEPSY
- FIBROMYALGIA
- GOUT
- HEADACHES
- HEARING LOSS (L or R)
- HEART ATTACK
- HEART MURMER
- HEPATITIS
- HIGH BLOOD PRESSURE
- HYPERTHYROID
- HYPOTHYROID
- KIDNEY FAILURE
- LIVER DISEASE
- LOW BLOOD PRESSURE
- LOW CHOLESTEROL
- MULTIPLE SCLEROSIS
- NERVOUSNESS
- OSTEO-ARTHRITIS
- OSTEOPOROSIS
- PARKINSON'S DISEASE
- PERIPHERAL VASCULAR DISEASE
- PHLEBITIS
- POLIO
- PYSCHIATRIC DISORDER
- RUSH
- RHEUMATIC FEVER
- RHEUMATOID ARTHRITIS
- RADIATION TREATMENT
- SHORTNESS OF BREATH
- SINUS PROBLEMS
- SLEEP APNEA
- STROKE
- SWELLING
- TIRED FEET
- TUBERCULOSIS
- ULCERS
- VARICOUS VEINS
- VENEREAL DISEASE
- WEIGHT LOSS

Other chronic illness not listed: _____

_____

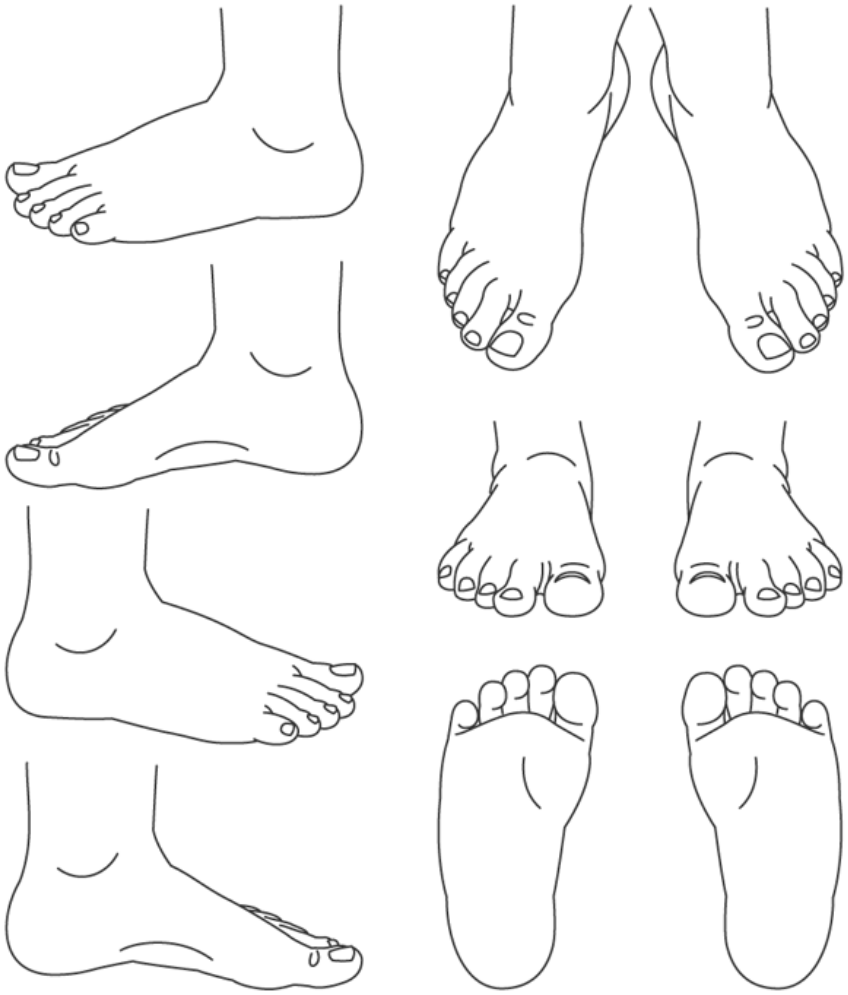
CONSENT

I certify that the above information is true and correct to the best of my knowledge. I give my permission to the doctor to administer and perform such procedures as may be deemed necessary in the diagnosis and/or treatment of my foot.

Signature: _____

WHERE DOES IT HURT?

On the diagram below please mark the place(s) where you are experiencing pain in your feet.



Regarding the place(s) you marked above, circle the symptoms of pain you experience.

Mild	Throbbing	Swelling
Moderate	Aching	Numbness
Severe	Burning	Tingling

Please list any additional symptoms you have been experiencing if not list above. _____

_____

HIPPA

NOTICE OF PRIVACY PRACTICES

Dr. Dawn Miles is committed to protecting the privacy and security of individual identifiable health information and other protected health information of a confidential nature for this medical practice as set forth in the Health Insurance Portability and Accountability Act (HIPPA).

HIPPA Compliance Patient Consent Form

Our Notice or Privacy Practices provides information about how we may use or disclose protected health information. The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent. The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date. You have the right to restrict how your protected health information is used and disclosed for treatment, payment, or healthcare operations. We are not required to agree with this restriction. but if we do. we shall honor this agreement. The EIIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations. By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form. I understand that:

- Protected health information may he disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information, but the practice does do not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

Mav we phone, email, or send a text to you to confirm appointments?	YES	NO
May we discuss your medical condition with any member of your family'?	YES	NO
If YES. please name the members allowed:	YES	NO

_____

Signature: _____ Print Name: _____

Date: _____

Authorization

I hereby give my permission for Dawn Miles DPM and her associates or assistants to examine and render treatment that may be necessary in the diagnosis and/or treatment of my foot and/or ankle condition(s) and release related information to my physician and/or emergency medical personnel as required by law.

It is your responsibility to verify that all requirements of your insurance plan are met. We will assist you with precertification for procedures ordered by our office, but it is ultimately your responsibility to verify whether any care rendered is covered by your insurance plan. We are not responsible for the expense of treatment which is not paid by your insurance. Although you have requested us to bill your insurance company in the case of surgery, you clearly understand that it is still your responsibility to make sure the bill is paid within a reasonable time frame.

I hereby authorize my insurance company to pay directly to Dawn Miles the benefits and amounts due and otherwise payable to me for medical supplies and services, as described on the customary charges for those supplies and services. I acknowledge and understand that I am responsible for all the charges for services rendered to me or any member of my immediate family. If for any reason, any portion of my bill is not paid by my insurance company, I further agree to make arrangements for prompt and timely payment of the balance. I further acknowledge that I have read and understand the financial policy. accept responsibility for payment of any balance owed on my account. I understand I am financially responsible for all charges whether or not paid by insurance. In the unforeseen event that a refund or overpayment is due to you. we will be happy to issue you a refund via business check upon request.

I understand that will be charged a non-refundable fee of $25 if I miss my appointment or cancel my appointment with less than 24-hour notice. This fee will need to be paid in advance or at the time of my next appointment. I understand that the purpose of this policy is to allow any available appointment to be used by patients that need to be seen.

AUTHORIZATION to RELEASE INFORMATION

I _____ hereby authorize Dr. Dawn Miles DPM to release any information regarding medical treatment for the purpose of validating and determining benefits payable in connection with any claims. I may revoke consent for the above item at any time in writing. I also understand that there is a non-refundable fee for any requested medical records or the completion of any term. including FMLA, and others.

Signature of Patient: _____

Date:_____