John E. Baker, D.P.M

Patient Registration Form

PLEASE PRINT

Patient Name: ____ Marital Status:______________

Date of Birth:___________________Age:________ Sex:________Social Security #:__________________________

Address:____City:_______________________Zip Code:__________

Home Phone:_(___)_____________________ Cell Phone: (___)_____________________

Occupation:__________________________Employer:_____________________Work Phone:_(___)_____________

How did you hear about our office?: (Circle one) Primary Dr Insurance Billboard Internet Newspaper Family Friend Yellow Pages Other____________________

Family Member(s) seen in office:____

Primary Care Physician:__________________________________ Last Date Seen:______________________

Primary Insurance: ________________________________ _____ID#: ______________________________

Subscribers Name: ___________________________ _________Relationship: ________________________

DOB:______________

Secondary Insurance: __________________________________ ID#: _______________________________

Subscribers Name: ____________________________________ Relationship: _________________________

DOB: _____________

Person Responsible for bills: ____________________________________

In Case of Emergency Person to Contact:

Name: ______________________________Phone #: (___)_________________Relationship:_______________

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 condition.

Parent/Guardian Signature: ____ Date: ______________________

All Patients, including Medicare Patients PLEASE READ.

I request that payment of authorized Medicare benefits be made either to me or on my behalf to John E. Baker, D.P.M. for any services furnished to me by that physician. I authorize any holder of medical information to release any information needed to determine these benefits or the benefits payable for related services. If "other health insurance" is indicated in item 9 of the HCFA-1500 form, or elsewhere on the approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, copayment and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare/Insurance carrier. I authorize my insurance benefits be paid directly to Dr. John E. Baker, D.P.M. I understand that I am financially responsible for any and all charges whether or not paid by insurance, any service deemed non-covered by insurance or item that insurance does not cover. I also authorize Dr. Baker or insurance company to release any information required to process my claims.

Patient/Guardian Signature: ________________________________ Date: _______________

Relationship to Patient: _________________________________

Please describe what brings you into the office today: ____
____

How would you describe your pain?:

Sharp   Aching   Throbbing   Shooting   Electrical   Pins and Needles   Burning

Location of pain or primary complaint:

Lower leg   Ankle   Achilles Tendon   Heel   Midfoot   Arch   Forefoot
Sole of Foot   Ball of Foot   Top of Foot   Big Toe   Lesser Toes   Toenails

How long has your problems been present?:

1-3 days   3-7 days   1-3 weeks   3-6 weeks   6-8 weeks   3-6 months
6-9 months   9-12 months   Greater than 1 year

Onset of condition or injury:

Gradual onset over time   Sudden onset from activity or injury

Pain/Condition aggravated by:

Any Weight Bearing   Standing Walking   Running   Exercise   Bending   Stooping   Pressure to ball of foot   Pressure from shoes   Jumping

Course/Progression of condition:

Sever Worsening   Moderate Worsening   Mild Worsening   Steady/Unchanged
Mild Improvement   Moderate Improvement   Considerable/Good Improvement

Have you attempted any treatments to relieve your problem?:

Rest   Ice   Elevation   Change shoe gear   Over the counter padding
Over the counter anti-inflammatory medication (Motrin, Aleve, Tylenol, Aspirin, etc.)
In home whirlpool   Stretching   Trimming out toenail yourself   Applying skin cream
Applying topical antibiotic ointment

How much improvement/relief have you achieved with previous treatments?:

Mild Improvement   Moderate Improvement   Considerable Improvement
No Improvement/Worsening of Condition

<u>Podiatry History</u>

Is there any personal or family history of diabetes? ____Yes ____No
Do you smoke? _____ If yes, how many packs a day? _____ How many years? _______

Have you ever been to a Podiatrist before? ____Yes ____No
If yes, please list.   Name: ____________________ Last Visit: ____________________

Please indicate which foot problems you now have or have had in the past:

Ankle Pain	____Yes____No	Corns/Callouses	____Yes____No
Athlete's Feet	____Yes____No	Cramps/Numbness	____Yes____No
Bunions	____Yes____No	Flat Feet	____Yes____No
Heel Pain	____Yes____No	Swelling in Feet/Ankle	____Yes____No
Ingrown Toenail	____Yes____No	Tired Feed	____Yes____No
Plantar Wart	____Yes____No		

Medical History

AIDS/HIV	Yes No	Hepatitis or Jaundice	Yes No
Allergies to anesthetics	Yes No	High Blood Pressure	Yes No
Allergies to Medicine or Drugs	Yes No	Kidney Problems	Yes No
Anemia	Yes No	Liver Disease	Yes No
Angina	Yes No	Low Blood Pressure	Yes No
Arthritis	Yes No	Nervous Problems	Yes No
Artificial Heart Valves or Joints	Yes No	Phlebitis	Yes No
Asthma	Yes No	Psychiatric Care	Yes No
Back Problems	Yes No	Radiation Treatment	Yes No
Bleeding Disorders	Yes No	Rash	Yes No
Cancer	Yes No	Respiratory Disease	Yes No
Chemical Dependency	Yes No	Rheumatic Fever	Yes No
Chest Pain	Yes No	Shortness of Breath	Yes No
Chronic Diarrhea	Yes No	Sinus Problems	Yes No
Circulatory Problems	Yes No	Special Diet	Yes No
Diabetes	Yes No	Stroke	Yes No
Ear Problems	Yes No	Swelling in Ankles/Feet	Yes No
Epilepsy	Yes No	Swollen Neck Glands	Yes No
Eye Problems	Yes No	Tired Feet	Yes No
Fainting	Yes No	Tuberculosis	Yes No
Foot or Leg Cramps	Yes No	Ulcers	Yes No
Gout	Yes No	Varicose Veins	Yes No
Headaches	Yes No	Venereal Disease	Yes No
Heart Disease	Yes No	Weight loss unexplained	Yes No
Hemophilia	Yes No		

Surgeries You Have Had:
____
____

Hospitalization other than for surgeries listed above:
____
____

Are you now or have you been under any doctor's care for any reason over the past two years?
If yes, please explain:____

Medications

Include prescriptions, over the counter
Medications and vitamins ______________________________
____
____
____
____
____
____

Pharmacy Name:______________________________
Pharmacy Phone:______________________________

Allergies

___Adhesive Tape	___Local Anesthetics
___Anticoagulant	___Novocain
___Aspirin	___Penicillin
___Codeine	___Seafood
___Demerol	___Sulfa
___Iodine	___Other_________________

You’re Rights as a Patient

You have the right to restrict the disclosure of you protected health information (In writing). The request for restriction may be denied if the information is required for treatment, payment or health care operations.

- You have the right to receive confidential communications regarding you protected health information.
- You have the right to inspect and copy your protected health information.
- You have the right to amend your protected health information.
- You have the right to receive an account of disclosures of your protected health information.
- You have the right to a paper copy of this notice of privacy practice.

Legal Requirements

John E. Baker, D.P.M. is required by law to maintain the privacy of you protected health information. We are required to abide by the terms of this notice as it is currently stated, and reserve the right to change this notice. The policies in any new notice will be in effect until they are posted to this site, or are available within our office.

Complaints

If you have complaints regarding the way your protected health information was handled, you may submit a complaint in writing to our office. You will not be retaliated against in any manner for a complaint.

Practice’s Requirements

The Practice

- Is required by federal law maintain the privacy of your PHI and to provide you with this privacy notice detailing the practice’s legal duties and privacy practices with respect to you PHI.
- May be required by State Law to maintain greater restrictions on the use or release of you PHI than that is provided for under federal law. In particular the practice is required to comply with the following state statutes: Health General Article, Title 4, Subtitle 2, Confidentiality of Medical Records and Subtitle 4, Personal Medical Records.
- Is required to abide by the terms of this privacy notice.
- Reserves the right to change the terms of this privacy notice and to make the new privacy notice provisions effective of all PHI that it maintains.
- Will distribute any revised privacy notice to you prior to implementation.
- Will not retaliate against you for filing a complaint.

Effective Date

This notice is in effect as of January 1, 2003.

Patient Acknowledgement

By subscribing my name below, I acknowledge receipt of a copy of this notice and my understanding my agreement to its terms.

Patient Signature: ____ Date: _______________________

NO SHOW POLICY

There will be a $25.00 fee for a no show appointment. This fee will be charged to you and not you insurance company. If you need to cancel, or reschedule your appointment please give 24 hour advance notice, as we have a long list of patients waiting to see Dr. Baker.

Thank you.

Signature of Insured/Guardian: ____

Date: _________________________

John E. Baker, D.P.M., P.A.

NOTICE OF PRIVACY PRACTICE

In accordance with the Health Care Portability and Accessibility Act (HIPPA), and as a service to your valued patients and customers, we are posting our Notice of Privacy Practice here.

Note: This Notice of Privacy Practice is provided for educational and informational purposes only. This Notice is not intended as legal advice, and is not provided for adoption of publication by any party. The form publication of any such notice may create legal obligations or liabilities, which may vary depending upon the legal status and business operations of different organizations. The form and content of any Notice of Privacy Practice should be determined only upon informed consultation with qualified legal counsel.

THIS NOTICE IS EFFECTIVE APRIL 13, 2003 UNTIL FUTHER NOTICE

Right TO Notice

As a patient, you have the right to adequate notice of the uses and disclosures of your protected health information. Under the Health Insurance Portability and Accessibility Act (HIPPA), Dr. John E. Baker can use your protected health information for treatment, payment and health care options.

A) Treatment-We may use or disclose your health information to a physician or other healthcare providing treatment to you.
B) Payment- We may use and disclose your health information to obtain payment for services provided to you.
C) Health Care Operations- We may use and disclose your health information in connection with our health operations. Including quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

You're Authorization

Most uses and disclosures that do not fall under treatment, payment, and health care operations will require you written authorization. Upon signing, you may revoke your authorization (in writing) through our practice at any time.

Emergency Situations

In the event of you incapacity or an emergency situation, we will disclose health information to a family member, or any other person responsible for your care, using our professional judgment. We will only disclose health information that is directly relevant to the person's involvement in your health care.

Marketing

We will not use your health information for marketing communications without written authorization.

Required by Law

We may also use or disclose your health information when we are required to do so by law.

Abuse or Neglect

We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect or domestic violence or the victim of other crimes. We may disclose your health information to the appropriate authorities under certain circumstances.

National Security

We may disclose the health information of Armed Forces personnel to military authorities under certain circumstances. We may disclose health information to authorized federal officials required for lawful intelligence, counterintelligence and other national security activities. We may disclose health information of inmates or patients to the appropriate authorities under certain circumstances.

Appointment Reminders

We may use or disclose your health information to provide you with appointment reminders via phone, e-mail or letter.

Transportation of Charts

If charts need to leave the office in the cases of surgery, house calls, nursing homes, ETC. They will be transported in a secure container.