Lansing Podiatry, PLLC
1500 Watertower Place Ste 300.
East Lansing, MI 48823

PATIENT DEMOGRAPHICS

Print Date 3/17/2020

Account #: DOB:

Patient Name:_____

Address:_____

Home Phone: Gender:
Account Category: Age:
Social Security #: ____-___-____

Primary Provider:
Referring Provider:

Ethnic Group: ☐ Not Hispanic or Latino ☐ Hispanic or Latino ☐ Other _____ ☐ Decline to answer

Race: ☐ American Indian or Alaskan Native ☐ Asian ☐ Black or African American ☐ White

☐ Hawaiian or Pacific Islander ☐ Other _____ ☐ Decline to answer

Preferred Language: ☐ English ☐ Spanish ☐ Other _____

Patient Contact Information: Home: Work: Cell:

Email address:

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

How would you prefer to be contacted: ☐ Phone ☐ Mail ☐ Portal Email

How would you prefer to receive reminders from our office? ☐ Home Phone ☐ Cell Phone ☐ Work Phone

Preferred Pharmacy: _____ Location: _____ Pharmacy Phone: _____

MAIL ORDER PHARMACY: _____

HIPAA Consent for Use and Disclosure of Your Health Information

By specifying and signing below, you are authorizing Lansing Podiatry, and its staff to leave a message on an answering machine, voicemail or with a specified individual, which may include sensitive and/or protected health information.

I **Do____ Do not____** authorize Lansing Podiatry, to leave detailed messages regarding my medical condition or treatment on my voicemail.

_____ **Release my medical information to myself ONLY.**

_____
Initial

_____ _____
Patient Signature **Date**

PRINT FULL NAME: _____

IF PATIENT IS A MINOR- SIGNATURE OF PARENT/LEGAL GUARDIAN: _____

Insurance Authorization

- I authorize the release of any medical information necessary to process my claim and collect payment.
- I authorize payment of medical benefits to Lansing Podiatry, for services rendered when they request that payment be made directly to them.
- I understand that I am ultimately responsible for payment of services that are rendered to me.
- I understand that Lansing Podiatry, will bill my insurance company, however I am responsible for any balance that my insurance does not pay.
- I acknowledge that I am responsible for all copayments and/or deductibles.
- I am aware I am responsible for all costs associated with collection agency fees, attorney fees, and court costs associated with the collection of my debt if applicable.

_____
Initial

Physician Consent for Medical Treatment

I, the undersigned, hereby authorize and direct Dr. _____to treat my condition. I hereby voluntarily consent for care encompassing diagnostic procedures and treatment by my physician, his assistant, designees or consultants, as may be necessary in the judgment of my physician. I am aware that the practice of medicine is not an exact science, and I acknowledge that no guarantees have been made as to the results of the treatments or examination in this clinic. I understand that my medical record may be maintained and authorize access to persons involved in my care.

_____
Initial

HIPAA Acknowledgement of Receipt of Notification of Privacy Practices

I have been made aware of the Lansing Podiatry Notice of Privacy Practices. The notice is posted in the waiting area of the Lansing Podiatry office. By signing below, I acknowledge that I have been offered this notice, offered a chance to read this notice, and am aware that I can request a copy of this notice to take with me if so desired.

_____
Initial

HIPAA Authorization for release of Protected Health Information

If you choose to have your Protected Health Information released to another person, either verbally or in writing, please complete the information below. Initialing the below authorization will not affect your treatment at Lansing Podiatry, PLLC.

I, **_____,** approve Lansing Podiatry, PLLC, to release my health records to the individuals listed below at my request. I understand this authorization is valid for one year from this date and can be revoked or revised at any time with written notice.

Name: _____ **Relationship:** _____
Name: _____ **Relationship:** _____
Name: _____ **Relationship:** _____

PATIENT HISTORY

This is a confidential record and will be kept in your electronic patient chart.

Information contained here will not be released to anyone without your authorization to do so.

TODAY'S DATE ____/____/____ **DATE OF BIRTH ____/____/____**

PRINT PLEASE LAST NAME _____ FIRST NAME _____ M.I. ____

Family Doctor: _____

Reason for seeing the physician: _____

Have you been exposed to or currently have TB (tuberculosis)? **Y N**

Have you received the Pneumonia Vaccine in the last 9 years? **Y N Date _____**

ALLERGIES/REACTIONS TO ANY MEDICATION OR FOOD:

_____

_____

LIST CURRENT MEDICATIONS *(include over the counter items)*

MEDICATION/DOSAGE

1._____

2._____

3._____

4._____

5._____

PAST SURGICAL HISTORY – Check previous surgeries & provide date *(If nothing marked then NONE APPLY)*

____Appendectomy _____
____ Back Surgery _____
____Bladder Surgery _____
____ Breast Surgery _____
____Cesarean Section _____
____Cholecystectomy _____
____Colon Surgery _____
____Coronary Artery Bypass _____
____Coronary Stent _____
____Cystectomy _____
____Cystoscopy _____
____Gastric Bypass _____
____Green Light PVP _____
____Heart Valve Replacement _____
____Hernia Repair _____
____Hip Replacement _____
____Hydrocele Repair _____
____Hysterectomy _____
____Kidney Stone Removal _____
____Knee Replacement _____
____Laparoscopy _____
____Lithotripsy _____
____Mastectomy _____
____Nephrectomy _____
____Pacemaker Insertion _____
____ Other _____
_____
_____

PAST MEDICAL HISTORY – Check any previous past medical problems *(If nothing marked then NONE APPLY)*

____Anemia
____Angina
____Arthritis
____Asthma
____BPH
____Cancer _____
List type of cancer
____Cerebrovascular Accident
____Chronic UTIs
____Congestive Heart Failure
____COPD
____Coronary Artery Disease
____Depression
____Diabetes 1 OR 2
(circle one)
____Diverticular Disease
____GERD
____Gout
____Hepatitis C
____Hypercholesterolemia
____Hyperlipidemia
____Hypertension
____Hypothyroid
____Liver Disease
____Lupus
____Migraine Headaches
____Multiple Sclerosis
____Myocardial Infarction
____Osteoarthritis
____Osteoporosis
(____Hemo ____Peritoneal)
____Rheumatoid Arthritis
____Seizure Disorder
Other_____
_____
_____
_____

FAMILY HISTORY ***Indicate*** *what family member has the condition (**FATH, MOTH, SIS, BRO, DAU, SON**)*

Anesthesia Problems_____
Lung Problems_____
Heart Problems_____
High Blood Pressure_____
Kidney Disease_____
Stroke_____
Other_____
Bleeding Disorders_____
Cancer_____
Kidney Stones_____
Diabetes_____

SOCIAL HISTORY: Please Circle Answers

Marital Status: Married Single Divorced Widowed Legally Separated Annulled Life Partner Unknown

Smoking Status: (please circle and answer as appropriate)

Current Every Day Smoker: When did you start smoking? _____ Packs smoked per day? _____

Current Some Day Smoker: When did you start smoking? _____ Packs smoked per day? _____

Former Smoker: When did you quit? _____ Packs smoked per day _____ How long did you smoke? _____

Never Smoked Smoker, current status unknown Unknown if ever smoked

Do you use Smokeless Tobacco? (please circle): Yes No

Do you drink Alcohol? (please circle): Yes: How much do you drink? _____ Not Anymore Never Drank

Drinking habits? Social Light Moderate Excessive

Do you use recreational drugs? (please circle): Yes No

REVIEW OF SYSTEMS *(Please circle any symptoms you are currently experiencing)*

Constitutional:	Fever	Chills	Weight Loss
Eyes:	Blurry vision	Cataracts	Glaucoma
Ears, Nose, Mouth, Throat:	Hearing Loss	Nasal Stuffiness	Sore Throat
Cardiovascular:	Chest Pains	Swollen Ankles	Irregular Heartbeat
Respiratory:	Shortness of Breath	Wheezing	Chronic Cough
Gastrointestinal:	Abdominal Pain	Nausea/Vomiting	Change in Bowels
Genitourinary:	Incontinence	Painful Urination	Blood in urine
Musculoskeletal:	Chronic Back Pain	Chronic Neck Pain	Sore Muscles
Integumentary/Skin:	Rash	Persistent Itching	Skin Cancer History
Neurological:	Numbness	Tingling	Dizziness
Hematologic/Lymphatic:	Swollen Glands	Abnormal Bleeding	Transfusion History
Psychiatric:	Anxiety	Depression	

APPROXIMATE HEIGHT: _____ **WEIGHT: _____**

Have you had your flu shot within the last year ? Yes____ Month: _____ No____

Oct-March (G8482) Declined or advised: ___ (G8483)

Are you A Diabetic? Yes_____ No_____ IF YES what is your Hemoglobin A1C_____

When was your last A1C checked_____

NO SHOW/MISSED APPOINTMENT POLICY

We, at Lansing Podiatry, PLLC understand that sometimes you need to cancel or reschedule your appointment and that there are emergencies. If you are unable to keep your appointment, please call us as soon as possible (with at least a 24-hour notice). You can cancel appointments by calling the following number: 517-351-7640

To ensure that each patient is given the proper amount of time allotted for their visit and to provide the highest quality care, it is very important for each scheduled patient to attend their visit on time. As a courtesy, an appointment reminder call to you is made/attempted one (1) business day prior to your scheduled appointment. However, it is the responsibility of the patient to arrive for their appointment on time.

PLEASE REVIEW THE FOLLOWING POLICY:

1. Please cancel your appointment with at least a 24 hours' notice: There is a waiting list to see the clinician's at Lansing Podiatry, PLLC and whenever possible, we like to fill cancelled spaces to shorten the waiting period for our patients.

2. If less than a 24-hour cancellation is given this will be documented as a "No-Show" appointment and you will be charged $25.00.

3. If you do not present to the office for your appointment, this will be documented as a "No-Show" appointment.

4. If you have 1 "No-Show/Missed" appointments within a one-year time period will be assessed a $35.00 no show fee.

5. If you have 2 "No-Show/Missed" appointments within a one-year time, you will receive a second $35 no show fee assessment and you will also receive a warning letter for possible dismissal from our practice, if another no-show/missed appointment occurs within the same year.

6. After 3 "No-Show/ Missed" Dismissal from the practice will be considered.
   ***You will be notified by letter if the dismissal was approved.**

I have read and understand Lansing Podiatry, PLLC No Show/Missed Appointment Policy and understand my responsibility to plan appointments accordingly and notify Lansing Podiatry, PLLC appropriately if I have difficulty keeping my scheduled appointments.

_____ _____ _____

Patient Name Date of Birth Date

_____ _____

Patient Signature or Parent/Guardian if minor Relationship to Patient

_____ _____

Staff Signature Date