FRANKLIN
Foot Care
of Rhode Island

James A. Anderson, Jr. & Associates, Podiatric Physicians

Personal Information

Name: _____ Birthdate: _____ Age: _____

Address: _____ Marital Status (*circle*): M Sep D W Single Engaged

City: _____ State: ____ Zip: _____ Spouse/Partner Name: _____

Race: _____ Ethnicity: _____ Preferred language: _____

Patient SSN: ____ - ____ - _____ Email: _____@_____

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

In case of emergency contact:

Name: _____Relationship: _____

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

PCP: _____ Phone: _____ Last Medical Visit Date: _____

PHARMACY: _____ Address/Phone: _____

Who may we thank for referring you to our office: _____

****Person financially responsible for this account: (Skip if self)**

Name of responsible party: _____Relationship to patient: _____

Billing Address: _____ Phone number: _____

Insurance Information:

Primary Insurance Company: _____ Do you need a referral: _____

Subscriber: _____ Relationship to patient: _____ Subscriber Date of Birth: _____

Secondary Insurance Company: _____ Do you need a referral: _____

Subscriber: _____ Relationship to patient: _____ Subscriber Date of Birth: _____

I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance of my account for any professional services rendered. If my insurance requires authorization or referral, I am responsible for obtaining that information for all services rendered.
I have read all the information on both sides of this sheet and have completed the above answers. I certify this information is true and correct to best of my knowledge. I will notify you of any changes in my status or the above information.

Signature: _____ Date: _____

Relationship to patient: _____

NAME: _____ **DOB:** _____

MEDICAL INFORMATION:

Reason for Visit Today: *(Describe foot problems and concerns)* _____

_____

When Did Problem Start? _____ How long have you had your current symptoms? _____

Have your symptoms: *(please circle)* Increased Decreased Remained the same

Is this injury from an accident or work-related? _____

If yes, do you currently have a claim open with the insurance company? *(please circle)* No Yes

Please provide claim information to our office for billing: _____

MEDICAL HISTORY: *(please circle if you have ever been **diagnosed or treated** for any of the following)*

Diabetes	High Blood Pressure	Kidney disease (stage: _____)
Type I	Bleeding Disorder	Kidney failure
Type II	Clotting Disorder	On Dialysis
Thyroid Disorder	Heart Disease	Hepatitis/Liver disease
Epilepsy/Seizure Disorder	Heart Attack	Liver failure
Asthma	PVD (Circulation Disease)	GERD
COPD	Stroke	Stomach Ulcer
Lung Cancer	Varicose Veins	GI Bleed
Tuberculosis	Anemia	Nerve Disorder/Neuropathy
Arthritis/Osteoarthritis	High Cholesterol	Numbness/Tingling
Psoriatic Arthritis	Rheumatic Fever	Transplant: _____
Rheumatoid Arthritis	DVT / PE	Cancer (type: _____)
Gout		
Other: _____		Unknown medial history
Other: _____		No medical history

SURGICAL HISTORY: *(please include date if known)* _____

_____

_____

Please circle if: Unknown surgical history // No surgical history

SOCIAL HISTORY: *(please circle / write in answers)*

Tobacco: No – never / former (quit when _____) // Yes (____pack(s)/day x ____ years)

Alcohol: No – never / former (quit when _____) // Yes – how much, how often _____

Recreational drug use: No // Yes – what is used _____

FAMILY HISTORY: *(please circle if your siblings, parents, grandparents had these conditions)*

Diabetes Heart Disease Heart Attack Stroke Hypertension Anemia

Neuropathy Cancer (type: _____) Other: _____

No family history Unknown family history

NAME: _____ **DOB:** _____

MEDICATIONS: *(please list ALL medications you are currently taking – prescription, non-prescription, herbal, OTC – list name and dose)*

_____

_____

_____

_____

ALLERGIES: *(please list allergies AND reactions)*

_____ No Known Allergies

_____ Penicillin: _____ _____ Local Anesthetic: _____

_____ Iodine: _____ _____ Sulfa: _____

_____ Aspirin: _____ _____ IV Dye: _____

_____ Latex: _____ _____ Tape: _____

_____ Other: _____

_____ Other: _____

Signature: _____ **Date:** _____

Date updated: _____

Date updated: _____

Date updated: _____

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NAME: _____ **DOB:** _____

NOTICE OF PRIVACY PRACTICES

This note describes how medical information about you can be used and how you can get access to this information. Please read carefully.

Your medical record is protected under HIPAA federal law. There are limitations upon to whom and under what circumstances your medical information can be disclosed. **We do not share your private medical information with anyone including your spouse, parent, or employer unless you request it or unless required by law.**

The law allows us to share your medical information with your insurance company to verify eligibility and that payment is appropriated for the visit. They may also review your record to ensure that we meet quality standards. We share information with other providers who are treating you or who referred you to us for consultation or treatment. We also provide information about your care and diagnosis when we request tests at the hospital or labs, such as x-ray or laboratory testing. These other providers are also required to protect the confidentiality of your health information under HIPAA.

We may consult you by mail or leave a general message by phone, but we will not give your test results or other private information to a family member without your permission.

We are not affiliated with any drug companies or other marketing services and will not release your health information to anyone for the purpose of marketing services to you. We may, however, give you a reminder by phone of an upcoming appointment. We may disclose information to the FDA in the event of an adverse drug reaction, as required by law, to the Dept. of Public Health in the event of certain communicable diseases.

You may review your medical records or obtain a copy of them upon request. There is a charge for copying depending on the number of pages involved. HIPAA also allows you to make additions or corrections to your medical records. If you have questions about our policy of protecting your private medical record, you may discuss them with our office manager.

CANCELLATION POLICY

I understand the office requires 24 hours' notice for appointment cancellations. If 24 hours' notice is not provided, I understand I may be charged a $25 No-Show/Cancellation Fee.

PERMISSION TO TREAT

I hereby give permission to Franklin Foot Care to examine and/or administer treatment as necessary in the diagnosis & treatment of my foot problem(s), **including but not limited to in person visits as well as telehealth visits**. I certify that I and/or my dependents have insurance coverage or will pay privately & assign directly to Franklin Foot Care all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether paid by my insurance.

☐ I Accept ☐ I Decline the NOTICE OF PRIVACY PRACTICES
☐ I Accept ☐ I Decline the CANCELLATION POLICY
☐ I Accept ☐ I Decline the PERMISSION TO TREAT

Signature: _____ Date: _____

Relationship to patient: _____