

**FAMILY FOOT CENTER**  
**Stephen J. Chapman, D.P.M./C. Lynn Rosenbaum, D.P.M.**

*Please fill in as much information as you can to facilitate our ability to give you accurate and efficient treatment. If you have any difficulty reading or understanding the questions below, please do not hesitate to request assistance from our staff. Thank You.*

Date: \_\_\_\_\_

**PATIENT INFORMATION**

Patient name: Dr./Mr./Mrs./Ms: \_\_\_\_\_

Last First Middle

Date of birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Gender: \_\_\_\_ M \_\_\_\_ F

Social Security No.: \_\_\_\_\_ Driver License No.: \_\_\_\_\_ Exp. Date \_\_\_\_ State: \_\_\_\_\_

Marital Status: \_\_\_\_ Single \_\_\_\_ Married \_\_\_\_ Divorced \_\_\_\_ Widowed

Home Phone: ( ) \_\_\_\_\_ Work Phone: ( ) \_\_\_\_\_

Cell Phone: ( ) \_\_\_\_\_ E-Mail: \_\_\_\_\_

Address: \_\_\_\_\_

City State Zip Code

Place of Employment: \_\_\_\_\_ Occupation: \_\_\_\_\_

In case of emergency contact: \_\_\_\_\_ Phone number: \_\_\_\_\_

If insurance is in Spouse's Name:

Spouse's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

Spouse's Place of Employment: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Spouse's Social Security Number: \_\_\_\_\_

Responsible Party of Minor Patient:

Guardian's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

Address: \_\_\_\_\_

Phone Number : \_\_\_\_\_

Social Security Number: \_\_\_\_\_

Whom may we thank for referring you: \_\_\_\_\_

Please check any that affected your decision in coming to see us:

- |   |                                       |                                      |
|---|---------------------------------------|--------------------------------------|
| <input type="checkbox"/> I am a returning patient | <input type="checkbox"/> Newspaper Ad | <input type="checkbox"/> Street Sign |
| <input type="checkbox"/> Family/Friend            | <input type="checkbox"/> Phone Book   | <input type="checkbox"/> TV Ad       |
| <input type="checkbox"/> Co-Worker                | <input type="checkbox"/> Health Fair  | <input type="checkbox"/> Other       |

Referring physician: Dr. \_\_\_\_\_

Family physician: Dr. \_\_\_\_\_

Address: \_\_\_\_\_

Phone number: ( ) \_\_\_\_\_

Date of last visit with doctor: \_\_\_\_\_

Pharmacy: \_\_\_\_\_ Phone Number \_\_\_\_\_

**ASSIGNMENT OF BENEFITS:** I authorize payment of medical benefits to the named provider(s) of professional services rendered. I authorize release of any medical information necessary to process this claim. I verify that the above information and medical history is correct to the best of my knowledge. I give my permission to the named provider(s) at Family Foot Center to perform and administer any necessary procedures.

\_\_\_\_\_  
PATIENT SIGNATURE DATE

\_\_\_\_\_  
Assisting Staff initial Date

**CHIEF COMPLAINT:**

Please check any of the following conditions you are currently experiencing or suffering from:

- |   |   |  |  |
|---|---|--|--|
| <input type="checkbox"/> Ankle Pain           | <input type="checkbox"/> Fracture       | <input type="checkbox"/> Ingrown Nail    | <input type="checkbox"/> Thick Nails/Nail Fungus |
| <input type="checkbox"/> Bunion               | <input type="checkbox"/> Gout           | <input type="checkbox"/> Rash            | <input type="checkbox"/> Tendonitis              |
| <input type="checkbox"/> Circulation Problems | <input type="checkbox"/> Growth/Tumor   | <input type="checkbox"/> Sore (Ulcer)    | <input type="checkbox"/> Trauma                  |
| <input type="checkbox"/> Corn/Callus          | <input type="checkbox"/> Hammer Toe     | <input type="checkbox"/> Swelling        | <input type="checkbox"/> Wart                    |
| <input type="checkbox"/> Diabetic Foot Check  | <input type="checkbox"/> Heel/Arch Pain | <input type="checkbox"/> Tailor's Bunion |  |

What is the nature of your problem? \_\_\_\_\_

- |           |                                |         |   |
|-----------|--------------------------------|---------|---|
| Location: | <input type="checkbox"/> Left  | Course: | <input type="checkbox"/> Getting Worse  |
|           | <input type="checkbox"/> Right |         | <input type="checkbox"/> Getting Better |
|           |                                |         | <input type="checkbox"/> Stays the Same |

How long has this been present? \_\_\_\_\_ Days \_\_\_\_\_ Weeks \_\_\_\_\_ Months \_\_\_\_\_ Years

- |        |                                  |                |   |
|--------|----------------------------------|----------------|---|
| Onset: | <input type="checkbox"/> Sudden  | Aggravated By: | <input type="checkbox"/> Increased Activity   |
|        | <input type="checkbox"/> Gradual |                | <input type="checkbox"/> Pressure             |
|        |                                  |                | <input type="checkbox"/> Putting weight on it |

**TREATMENT:**

Did you see any other doctor for this problem before? Yes  No

If yes, please explain when and type of treatment: \_\_\_\_\_  
\_\_\_\_\_

Was this due to an accident? Yes  No

If so, when (date): \_\_\_\_\_  
How did it happen? \_\_\_\_\_

**ALLERGIES:**

No Known Drug Allergies

Please list all known allergies (medications, tape, metals, etc.):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**MEDICATIONS/VITAMINS:**

Please list all medications/vitamins you are currently taking:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Weight: \_\_\_\_\_ lbs.

Height: \_\_\_\_\_

**FEMALE PATIENTS:**

**ARE YOU CURRENTLY PREGNANT?**

- Yes
- No



## **REVIEW OF SYSTEMS:**

### **Constitutional (Please circle all that apply):**

Chills  
Depression  
Easily Tired/Fatigue  
Fever

Sleep Difficulty  
Night Sweats  
Weight Change

### **Cardiovascular (Please circle all that apply):**

Chest Pain  
Discoloration of toes/foot  
Dizziness  
Leg Cramps  
Leg pain occurs at same distance  
Shortness of breath when lying flat (Orthopnea)

Pain or fatigue in feet/legs with exercise/activity  
Palpitations  
Swelling in feet/legs (Edema)  
Rapid Heart Beat (Tachycardia)  
Varicose Veins

### **Respiratory (Please circle all that apply):**

Shortness of Breath/Difficulty breathing  
Cough (acute)  
Cough (chronic)  
Cough with blood-tinged sputum (Hemoptysis)

Emphysema  
Exposure to TB  
Wheezing

### **Gastrointestinal (Please circle all that apply):**

Abdominal Pain  
Acid Reflux  
Bloating  
Constipation  
Diarrhea  
Heartburn

Hemorrhoids  
Nausea  
Stomach Ulcer  
Stool changes  
Vomiting

### **Musculoskeletal (Please circle all that apply):**

Ankle Instability (easy twisting injuries)  
Back Pain  
Difficulty/Pain with brisk walking/running  
Flat Feet  
Joint Pain  
Leg Pain (shin splints)

Muscle Aches  
Pain in feet getting out of bed  
Swelling in joint  
Swelling leg  
"Toe-in" or "Toe-out" gait (walking)

### **Integumentary (Please circle all that apply):**

Atypical moles  
Dry skin  
Pruritis (itching)

Rashes  
Sores on foot or leg

### **Neurological (Please circle all that apply):**

Burning in Feet  
Easy to Fall  
Headaches  
Memory Loss  
Numb Feet  
Pain up the leg  
Pain down the leg

Pain to Toes  
Seizures  
Tingling in Feet  
Tremor  
Vertigo/Dizziness  
Weakness in Feet

### **Hematology (Please circle all that apply):**

Easy Bruising  
Excessive Bleeding

History of Blood Transfusion  
Swollen lymph nodes

### **Endocrine (Please circle all that apply):**

Difficulty Urination  
Excessive Sweating  
Frequent Urination  
Hair Loss

Heat/Cold intolerance  
Increased Hunger (Polyphagia)  
Increased Thirst (Polydipsia)

### **Allergic/Immunologic (Please circle all that apply):**

Difficulty Healing  
Frequent Illness  
Hepatitis  
HIV Exposure  
Hives (Urticaria)  
Seasonal Allergies

None of the Above

# FAMILY FOOT CENTER

# NOTICE OF PRIVACY PRACTICES

## USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

*This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully. The privacy of your medical information is important to us.*

We are required by law to maintain the privacy of your health facts and to provide you with this notice of our legal duties and privacy practices. We must follow the terms of the notice in effect right now, but we reserve the right to change the terms. If there is a change, we will provide you with a written, revised notice upon request.

As a patient of ours, facts about you must be used and disclosed to other parties for treatment, payment and health care operation. These uses and disclosures require your consent, and include, but are not limited to the following information:

- A release of information contained in financial and/ or medical records;
- Diseases which spread from person to person, such as Human Immune Deficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS);
- Drug and/or alcohol abuse;
- Psychiatric diagnosis and treatment records;
- Laboratory test results;
- Medical history;
- Treatment progress;
- Any other related facts.

We may release the above to:

1. Your insurance company, Medicare, Medicaid, or any other person who will pay your bill for services or who will process your bill for services in order for us to receive payment;
2. Any person from a program or an insurance company, who performs billing, quality and risk management tasks, such as insurance auditors and state Risk Management;
3. Any hospital, nursing home or other health care facility where you may have testing done or to which you may be admitted;
4. Any assisted living or personal care facility where you live;
5. Any doctor providing your care;
6. State and/or Federal agencies acting on behalf of programs, such as Medicare, Medicaid, including state surveyors or auditors for any programs;
7. Other health care people to start treatment.

We may contact you to:

1. Provide appointment reminders or missed appointments or news about other health care programs we provide.

We are allowed to use or disclose facts about you without consent in the following situations:

1. In emergency treatment situations, if we try to obtain consent as soon as possible after treatment;
2. Where significant barriers to communicating with you exist and we determine that the consent is clearly inferred from the situation;
3. Where we are required by law to provide treatment and we are unable to obtain consent;
4. Where the use or disclosure is required by law. For example, we must disclose your protected health information to the U.S. Dept. of Health and Human Services upon request for purposes of determining whether we are in compliance with federal privacy laws;
5. Where we reasonably believe you are a victim of abuse, neglect, or domestic violence to a government agency authorized to receive abuse, neglect or domestic violence reports;
6. Health care oversight activities;
7. Certain legal administrative proceedings;
8. Certain law enforcement purposes;
9. To coroners, medical examiners and funeral directors in certain situations (home health, etc);
10. For certain research purposes;
11. To avoid a serious threat to health and safety;
12. For specialized government functions, including military and veterans' activities, national security and intelligence activities, protective services for the President and others, medical suitability determinations, correctional institution and custodial situation;
13. For Workers' Compensation purposes;
14. For quality assessment activities, employee review activities, training of students; licensing, and conducting or arranging other business activities. For example, we may call you by name when your doctor is ready to see you.

15. To provide you with information about treatment alternatives or other health-related benefits and services that may be of interest to you. We may also send you information about products or services that we believe may be beneficial to you.

We are allowed to use or disclose facts about you without consent or authorization provided you are informed in advance and given the chance to agree to, restrict or forbid the disclosure in the following situations:

1. To a family member, friend or other person you choose, who may assist in your care or payment for care.

Other uses and disclosures will be made only with your written approval. That approval may be withdrawn in writing at any time, except in limited situations.

*YOUR RIGHTS*

You have the right, subject to certain conditions, to:

- 1. Request restrictions on certain uses and disclosures of facts about you by filling out our Request form. However, we are not required to agree to the requested restrictions.
- 2. Receive confidential communication of protected health data by giving us another address or means of receiving health data.
- 3. Inspect and copy protected health data by filling out our request form.
- 4. Amend protected health data by filling out our form.
- 5. Receive a list of disclosures made of your protected health data by filling out our request form.
- 6. Obtain a paper copy of this notice upon request, if you agreed to receive this notice by e-mail, fax or website.

*COMPLAINTS*

You may complain to us and the Secretary of the U.S. Department of Health and Human Services if you believe that your privacy rights have been violated. There will be no retaliation against you for filing a complaint. The complaint must be filed out in writing with us and must state the specific incident(s) including the date, what happened and details of the incident.

For details about filing a complaint with us, contact Susie Fabyunkey, HIPAA Compliant Officer, phone number (931)528-1331.

*ACKNOWLEDGMENT*

I have read this Notice or have had it explained to me. I understand this Notice and have had the chance to ask questions about any matters I don't understand.

.....  
Signature of patient (or authorized representative)      Date

For Staff Use Only

The following good faith efforts were made to obtain acknowledgement:.....

.....  
However, acknowledgment was not obtained because:.....

.....  
.....Signature:.....Date:.....

**FAMILY FOOT CENTER**  
***Stephen J. Chapman, D.P.M.***  
***C. Lynn Rosenbaum, D.P.M.***  
**1-800-955-3338**  
**(931) 528-1331**

***RELEASE, ASSIGNMENT AND CONSENT***

Date: \_\_\_\_\_

I here by authorize Stephen J. Chapman, D.P.M. d.b.a. Family Foot Center and/or his associates to release to all my insurance companies including Medicare, Medicaid, Blue Cross/Blue Shield, CIGNA, United Healthcare, or any other insurance carrier; any information necessary including, but not limited to, the diagnosis, and records of any treatment or examination or surgery rendered to me on any date.

I authorize and request payment to go directly to Stephen J. Chapman, D.P.M. d.b.a. Family Foot Center the amount due for the services rendered to the patient whose name appears below. In the event the insurance reimbursement is paid directly to me, I hereby agree to forward this check to Family Foot Center within seven (7) days or I will be billed and held accountable for the entire amount billed.

I authorize the use of this form in all my insurance admissions, and I permit a copy of this authorization to be as valid as the original.

In the event that this account becomes delinquent, I agree to pay all costs of collection which will include a collection fee of 31% and a Legal collection fee of 42% to be added to my balance and any applicable court costs.

\_\_\_\_\_  
Patient Name (print)

\_\_\_\_\_  
Patient *Signature* or  
Parent's *Signature* of Minor

If signed by an "X", TN State law requires two witness signatures.

\_\_\_\_\_  
Witness #1

\_\_\_\_\_  
Witness #2