MILTON W. RICHARDSON, DPM
Confidential Patient Information

Name: ______________________________ **Sex**: __________ **Shoe Size**: ____________________

Marital Status: ________ **Date Of Birth**: ____________________ **Age**: ________ **Area Code Home Phone #**: ______________________________

Address: ______________________________ **Apt.**:____ **City**: ____________________ **State**: _____ **Zip Code**: __________

SSN: ________________________ **Employment**: ____________________________ **Work Phone**: ____________________

Email address: ____________________________________ **Cell Phone**: ______________________________

Spouse's Name: ____________________ **Spouse's SSN**: ______________________ **Work Phone**: ____________________

Primary Dr. __________________________ **Address:** ____________________________ **Phone**: __________________

Pharmacy Name and Telephone Number: ____

Who/How referred you to our office: ____________________ **Present Complaint:** ______________________________

List other doctor (s) seen for this condition: ______________________________ **When?** ________________

Medical History

- **Medical History of Diseases** ____
- **Drug Allergies** ______________________________ **Penicillin**______ **Codeine**______ **Tape**_____ **Iodine**_______
- **Novacaine** ______________________ **Steroids** __________ **Diuretics** __________ **Digitalis Preparations** __________
- **Bleeding Tendencies** ____
- **Surgery History** ____
- **Illness** ____
- **Jaundice** ____
- **Family History of Diseases (Father)**__________________________ **(Mother)**__________________________
- **(Brother)** ______________________ **(Sister)**____________________ **(Grandparents)**____________________

Have you been treated by a physician for any health condition in the last year? ______________________________

Medications: Please List: ____

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INSURANCE: Primary: ____________________________________ **Secondary:** ______________________________

Co-Pay: __________ **Have you met your deductible for the year?**________ **Amount of Deductible**: ______________________

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account upon receipt. I permit this office to endorse co-issued remittances for the conveyance of credit to my account. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I hereby authorize the doctor at Milton W. Richardson, DPM and whomever may be designated as their assistant to administer treatment as they so deem necessary and also authorize the release of any information acquired in the course of my examination or treatment. I certify that the above information is true and correct.

Patient's, Parent's /Guardian's Signature: ______________________________ **Date:**________________

<u>OUR PRIVACY PLEDGE</u>

Dr. Milton Richardson and members of the practice staff may need to use your name, address, phone number, and your clinical records to contact you with appointment reminders, information about alternative treatments, or other health related information that may be of interest to you. If this contact is made by phone and you are not home or work, a message will be left on your answering machine. A postal mailing could also be used. By signing this form, you are giving us authorization to contact you with these reminders and information.

<u>There are several circumstances in which we may have to use or disclose your health care information.</u>

- **<u>We may have to disclose your health information to another health care provider or a hospital if it is necessary to refer you to them for the diagnosis, assessment, or treatment of your health condition.</u>**
- **<u>We may have to disclose your health information and billing records to another party if they are potentially responsible for the payment of your services.</u>**
- **<u>We may need to use your health information within our practice for quality control or other operational purposes.</u>**

<u>If we make a change to our privacy practices, we will notify you in posting when you come in for treatment or by mail. Please feel free to call us at any time for a copy of our privacy notices.</u>

We are very concerned with protecting your privacy. While the law requires us to give you this disclosure, please understand that we have, and always will, respect the privacy of your health information.

There are several times in which we may have to say or disclose your name out loud regarding your health care or health care information.

- We may have to say or disclose your name out loud to receive information while you are in the waiting room.
- We will call you by your name when it is time for your appointment.

I have read your consent policy and agree to its terms.

<u>INSURANCE</u>

I understand and authorize this office to file my insurance for me and for services rendered. I understand that I am liable for payment of equipment and procedures NOT covered by my insurance (Post OP shoes, ankle walkers, routine foot care, etc). Medicare and Medicaid DO NOT cover post-op shoes or ankle walkers. Note: Co-pays are due at time of service paid in full.

______________________________	______________________________
Printed Name	Authorized Provider Representative
______________________________	______________________________
Signature	Date