RAINES FOOT CLINIC

PATIENT'S FULL NAME _____
DATE OF BIRTH _____ AGE _____ SEX F __ M __ SS# _____
ADDRESS _____
CITY _____ STATE _____ ZIP _____
HOME PHONE _____ WORK PHONE _____ CELL _____
Email _____
MARITIAL STATUS S __ M __ D __ W __ STUDENT: YES NO
EMPLOYMENT: FULL TIME_____ PART TIME_____ NOT_____ RETIRED_____
EMPLOYER _____ OCCUPATION _____
SPOUSE OR PARENT #1 _____ DATE OF BIRTH _____
SS# _____ EMPLOYER _____ WORK PHONE _____
Address if different _____ CELL PHONE _____
PARENT #2_____ DATE OF BIRTH _____
SS# _____ EMPLOYER _____ WORK PHONE _____
Address if different _____ CELL PHONE _____

RESPONSIBLE PARTY (if other than self) _____ DATE OF BIRTH _____
RELATIONSHIP TO PATIENT _____ PHONE _____
ADDRESS IF DIFFERENT _____
SS# _____ EMPLOYER _____ WORK PHONE _____
CELL PHONE _____

- **How did you know about Raines Foot Clinic?**_____
- **Who is your Primary Care Physician?** _____ **Phone** _____
- **What Pharmacy do you use?** _____ **Phone** _____

IN CASE OF EMERGENCY CONTACT (someone with different phone number than listed above)
NAME _____ RELATIONSHIP _____
ADDRESS _____ PHONE _____
CITY _____ STATE _____ ZIP _____

****PRIMARY INSURANCE**
NAME OF INSURANCE _____ PHONE _____
POLICY HOLDER _____ RELATIONSHIP _____
ID# _____ GROUP# _____ DOB OF POLICY HOLDER _____
COPAY _____ DEDUCTIBLE _____ **EDI PAYOR #**_____
****SECONDARY INSURANCE**
NAME OF INSURANCE _____ PHONE _____
POLICY HOLDER _____ RELATIONSHIP _____
ID# _____ GROUP# _____ DOB OF POLICY HOLDER _____

I hereby authorize the release of any pertinent information to my insurance company upon request and authorize my doctor to act as my agent in helping me obtain payment from my insurance. I assign all medical/surgical benefits on my behalf to RAINES FOOT CLINIC. I authorize use of this form on all my insurance submissions and permit a copy of this authorization to be used in place of the original. The undersigned severally agree, whether signing as a patient or otherwise, that in consideration of the services rendered to patient, payment of the account is guaranteed by the undersigned. While any insurance or other protection related to the account may be hereby assigned to and payable directly to us, the undersigned clearly understands that the obligation to pay the bill is primarily on the patient and the undersigned. While insurance received by us will applied to the patient's account, any part of the account not so paid by the insurance is nevertheless owing and should it be placed in the hands of a Collector or an Attorney for collection, all collection fees, attorney fees, cost and other expenses will be paid by the undersigned. The patient agrees that in the event his/her account is turned over for collections, and a lawsuit is instituted, that Obion County, Tennessee is the appropriate forum for such lawsuit, and the patient hereby consents to the jurisdiction of the Obion County, Tennessee courts.

PATIENT/GUARANTOR'S SIGNATURE _____ **DATE** _____

It is our practice to send a treatment summary letter to your primary care provider.

MEDICAL HISTORY

NAME_____**AGE**____**SEX**____**RACE**____**DATE**_____

PAST MEDICAL HISTORY

Please circle any that apply:

Artificial Heart Valves
Artificial Joints
Arthritis
Asthma
Bleeding Disorders
Cancer
Diabetes
Emphysema
Gout
Heart Attack
HIV/Aids
Rheumatic Fever
High Blood Pressure
Low Blood Pressure
Liver Disease
Lung Disease
Lupus
Kidney Disease
Hepatitis
Thyroid Disease
Stroke
Ulcers (Stomach)
Seizure Disorders
Other_____

SURGERIES:

List any surgery and date (including foot surgery).

HOSPITALIZATIONS:

ALLERGIES

Circle any that apply or write NONE.

Penicillin
Erythromycin
Keflex
Sulfa
Codeine
Demerol
Hydrocodone
Tylenol
Aspirin
Anesthetics (local)
Anesthetics (general)
Tape
Iodine
Other_____

FAMILY HISTORY

Circle any that apply or write NONE.

Diabetes
Hypertension
Bleeding Disorders
Circulatory
Problems with anesthesia

SOCIAL HISTORY

Alcohol **YES **NO**
Tobacco **YES **NO**
Tobacco: How much a day____How long_____
If QUIT, How much did you smoke & how long_____

MEDICATIONS

Please list all including prescriptions, over-the-counter medications and vitamins.

FORMER FOOT DOCTOR: _____ LAST VISIT _____

FAMILY PHYSICIAN: _____ LAST VISIT _____

I certify that the above information is true and correct to the best of my knowledge.

Patient's Signature_____Date_____

Feet First Podiatry/Raines Foot Clinic
Paul W. Hutchison, DPM
Dan Parise, DPM

1415 E. Reelfoot Ave, Union City, TN 38261
Phone (731)885-0220 Fax (731)885-0216
1901 Cook Street, Dyersburg, TN 38024
Phone (731)286-2139 Fax (731)286-2201

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORAMTION TO FAMILY AND /OR CAREGIVERS

In the event Feet First Podiatry/Raines Foot clinic may need to give your test results or medical information, may we..... (Check all that apply)

_____ Leave a detailed message on an answering machine.
_____ Leave a message with your spouse or family member.
_____ Call you on your cellular phone, the number is _____
_____ Call you at work, the number is _____
_____ Speak to you directly. ONLY

I, _____ (DOB) _____, give Feet First Podiatry/Raines Foot Clinic doctor and or staff, authorization to disclose my protected health information to the following family, friends and/or caregivers:

Name: _____Relatioship:_____Phone:_____
Name: _____Relatioship:_____Phone:_____
Name: _____Relatioship:_____Phone:_____
Name: _____Relatioship:_____Phone:_____

I understand that I have the right to revoke this authorization at any time. I understand that is I revoke this authorization I must do so in writing and present my written revocation to the Medical Records department.

I understand that the revocation will not apply to information that has already been shared in the process of treatment, payment or healthcare operations as sighted in the Notice of Privacy Practices.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization and I need not sign this form in order to assure treatment. I understand that nay disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by Federal Confidentiality Rules. If I have questions about the disclosure of my health information, I can refer to my Notice of Privacy, which I was offered a copy of from my doctor's office.

Unless, otherwise revoked, this authorization will expire on the following date, event or condition: _____. If I fail to specify a date **this authorization will expire one (1) year from the signature on this form.**

_____ Date_____
Signature of Patient

_____ Date_____
Signature of Guardian or Personal Representative

_____
Relationship to the patient

ACKNOWLEDGEMENT OF RECEIPT

OF

NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read if I so chose) and understood the notice.

_____ _____

Patient name (please print) Date

_____

Parent or Authorized Representative (if applicable)

_____

Signature