Moore Foot Ankle Specialists, PA

Patient Information (Confidential information – Important for our files and your health)

Patient Name: ______________________________
Last First Middle

Date of Birth: ____________ Age: ____ Sex: M / F SSN #: ________________ Marital Status: M / S / W / D

Race: ( ) African American ( ) American Indian / Alaskan Native ( ) Asian / Pacific Island ( ) Caucasian
( ) Hispanic Other: ______________________________

Street Address: ______________________________
Street City State Zip

Mailing Address: ______________________________
(If different from above) Street City State Zip

Home Telephone Number: ________________ Work Telephone Number: ________________

Occupation: ________________ Patient Employed by: ________________

In Case of an Emergency Notify: ________________ Relationship: ____________ Phone: ____________

Parent/Guardian Information:

Name of Responsible Party: ______________________________

Date of Birth: ________________ Social Security: ________________

Home Address: ______________________________
Street City State Zip

Home Telephone Number: ________________ Work Telephone Number: ________________

Relationship to Patient: ______________________________

Insurance Information: Please present insurance card(s) to receptionist

Pharmacy Name: ________________ **Pharmacy Phone Number:** ________________

How did you hear about this practice: Friend / Relative / Doctor / Healthcare provider / Health Event / Newspaper / Yellow Pages / Other: ________________

Who is your family doctor? ________________ **Whom may we thank for referring you?** ________________

Financial Responsibility and Assignment of Insurance Benefits:

The undersigned guarantees payment to Moore Foot & Ankle Specialists, P.A. of all charges for services provided to the patient. I understand that I am personally responsible for all charges not covered by the insurance. I authorize direct payment of surgical and medical benefits, which would otherwise be payable to me, to Moore Foot & Ankle Specialists, P.A. for services rendered. If covered by Medicare or Medicaid, I certify that the information provided by me in applying for payment under title XVIII and XIX of the Social Security Act is correct.

Authorization for Release of Medical Information:

The undersigned authorizes Moore Foot & Ankle Specialists, P.A., its physicians, practices or agents to disclose any medical information currently existing or developed during the course of treatment to: 1) the Social Security Administration or its intermediary, which may be needed for or related to Medicare or Medicaid claim; 2) state or federal agencies that provide benefits and require such information; 3) a referring physician or facility to which the patient my be referred; 4) third party payers or other involved in processing a claim for benefits for services rendered; 5) federal, state or local agencies as required to comply with the laws and regulations.

Authorization for Care and/or Treatment:

Knowing that I am suffering from a condition requiring health care treatment ("Treatment"), I voluntarily consent to such Treatment including diagnostic procedures and medical treatment ordered by my physician(s). I also voluntarily consent to Treatment provided by assistants, including medical and nursing students and/or other students in medically related fields, as judged necessary by my physician(s). I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me as the result of treatments or examinations by my caregivers. This form has been explained fully to me and I certify that I understand its contents. Consequently, I hereby release Moore Foot & Ankle Specialists, P.A., its employees, and agents and representatives from such legal responsibilities regarding my knowledge of and consent to medical treatment and from such other legal responsibilities to the extent permitted by law.

______________________________ ________________
Patient / Guardian or Parent if Minor Signature **Date**

Patient Name: ______________________ **Date:** __________

History & Medical Information

1. **Explain your foot/ankle problem** ☐ Right ☐ Left ______________________

____

2. **Describe the pain/discomfort:** ☐ Burning ☐ Numbness ☐ Sharp ☐ Other ______________
3. **When did the pain/discomfort begin?** ______________________
4. **What makes the pain/discomfort better:** ______________________
5. **What makes the pain/discomfort worst:** ______________________
6. **List all medications/herbs/vitamins:** ☐ **NONE** ______________________

____

7. **Allergies:** (Describe reaction) ☐ **NONE**
   ☐ Penicillin __________ ☐ Aspirin __________ ☐ Narcotic Agent / Codeine __________
   ☐ Anesthesia __________ ☐ Shellfish __________ ☐ Sulfa Drugs __________
   ☐ Nickel / Metal __________ ☐ Radiographic Contrast Dye __________
   ☐ Other ______________________

8. **Past Medical and Family History**

Condition	Self	Family		Condition	Self	Family	
Anemia	☐	☐	______	Kidney Disease	☐	☐	______
Anesthetic Reaction	☐	☐	______	Liver Disease	☐	☐	______
Arthritis	☐	☐	______	Mental Retardation	☐	☐	______
Asthma	☐	☐	______	Mitral Valve Prolapse	☐	☐	______
Bleeding Disorders	☐	☐	______	Multiple Sclerosis	☐	☐	______
Cancer	☐	☐	______	Nails Disorders	☐	☐	______
Circulation Problems	☐	☐	______	Nerve Disorders	☐	☐	______
Diabetes Avg Glucose____	☐	☐	______	Obesity	☐	☐	______
Epilepsy	☐	☐	______	Phlebitis	☐	☐	______
Foot Problem(s)	☐	☐	______	Pulmonary Disease	☐	☐	______
Gout	☐	☐	______	Rheumatic Fever	☐	☐	______
Heart Disease	☐	☐	______	STD	☐	☐	______
Hepatitis	☐	☐	______	Skin Problems	☐	☐	______
High Blood Pressure	☐	☐	______	Stomach/Intest Problems	☐	☐	______
High Cholesterol	☐	☐	______	Stroke	☐	☐	______
HIV/AIDS	☐	☐	______	Thyroid Disorders	☐	☐	______
Injury Trauma - Major	☐	☐	______	Varicose Veins	☐	☐	______

9. **Surgical History:** Have you had surgery? ☐ Yes—if yes, describe below ☐ No

   Surgery / Date: ______________________

   ____

10. **Social History:** (Only check what is pertinent to you)
    ☐ Tobacco Use ☐ Alcohol Use ☐ Exercise habits______________
    ☐ Caffeine Use ☐ Drug use (recreational, IV)
11. **Occupation:** ______________ **Is your problem work related?** ☐ Yes ☐ No
12. **Are you currently pregnant?** ______________________
13. **Height:** ________ **Weight:** ________ **Shoe Size:** ________

For office use: B/P __________ Pulse ______ Resp. ______ Temp. ________

Review of Systems

Please check any of the following that you are **currently experiencing** or have **recently experienced.**

Constitutional:	Y	N
Generally do you feel well?	☐	☐
Do you feel fatigued during the day?	☐	☐
Does your problem limit your normal daily activities?	☐	☐
Do you have a fever?	☐	☐

Eyes:	Y	N
Do you wear glasses or contacts?	☐	☐
Do you have burning or itchy eyes?	☐	☐
Do you have sensitivity to light?	☐	☐
Do you have watering of your eyes?	☐	☐
Are your eyes frequently red?	☐	☐
Do you have eye pain?	☐	☐

Ears, nose, mouth & throat:	Y	N
Do you have ringing in your ears?	☐	☐
Do you get nosebleeds?	☐	☐
Do you have difficulty swallowing?	☐	☐

Cardiovascular:	Y	N
Have you noticed your legs or ankles swelling?	☐	☐
Do you have varicose veins?	☐	☐
Do you have cramps in your legs at night or at rest?	☐	☐
Do you have cramps in your legs when walking?	☐	☐
Do your feet feel especially cold?	☐	☐

Respiratory:	Y	N
Do you have chest pain?	☐	☐
Do you have difficulty breathing?	☐	☐
Do you have shortness of breath?	☐	☐
Have you had a cough lasting longer than 3 weeks?	☐	☐

Gastrointestinal:	Y	N
Do you have a loss of increase in appetite?	☐	☐
Do you have a history of stomach ulcers?	☐	☐
Do you have heartburn?	☐	☐
Does Aspirin cause stomach pain?	☐	☐
Do you have bloody or dark stools?	☐	☐

Genitourinary:	Y	N
Do you urinate more frequently than before?	☐	☐
Do you have pain with urination?	☐	☐
Do you have burning with urination?	☐	☐
Have you noticed blood in your urine?	☐	☐

Musculoskeletal:	Y	N
Do you have low back pain?	☐	☐
Do you have pain in your legs?	☐	☐
Do you have foot pain?	☐	☐
Do you have joint pain?	☐	☐
Do you have bone pain?	☐	☐
Do you have general muscle aches or pains?	☐	☐
Have you had swelling in your legs?	☐	☐
Have you had joint swelling or stiffness?	☐	☐
Have you noticed a change in the way you walk?	☐	☐
Is it difficult to climb stairs?	☐	☐
Are you experiencing a loss of strength in your legs?	☐	☐
Have you felt rigidity in your legs?	☐	☐
Do you limp when you walk?	☐	☐
Do your shoes wear out quickly or unevenly?	☐	☐

Integumentary (Skin):	Y	N
Do you have any skin problems?	☐	☐
Is your skin strongly sensitive when exposed to the sun?	☐	☐
Do you have any skin rashes?	☐	☐
Do you have any warts on your feet?	☐	☐
Do you have any moles, lumps, bumps on your skin?	☐	☐
Do you have extremely dry skin or cracking?	☐	☐
Do you have any open skin sores?	☐	☐
Are there unusual areas of discoloration on your skin?	☐	☐
Do you have any corns or calluses on your feet?	☐	☐
Are your nails unusually thick?	☐	☐
Are your nails deformed?	☐	☐
Are your nails ingrown and tender?	☐	☐
Do your nails cause you pain?	☐	☐
Do you have problems with your fingernails?	☐	☐
Do you have noticeable hair loss on your legs or feet?	☐	☐

Neurological	Y	N
Do you ever feel dizzy?	☐	☐
Do you often feel confused or disoriented?	☐	☐
Do you have problems with your balance?	☐	☐
Do you have frequent or reoccurring headaches?	☐	☐
Do you have seizures?	☐	☐
Do you have tremors of your extremities?	☐	☐
Do your legs often feel like they "are going to sleep"?	☐	☐
Do you have numbness in your legs?	☐	☐
-a feeling of burning in your legs?	☐	☐
-cramps or pain in the legs with walking or exercise?	☐	☐
-leg pain that is worse at night or at rest?	☐	☐
-leg pain all the time?	☐	☐
-experience shooting pain down your legs?	☐	☐
-paralysis (complete loss of muscle strength) in legs?	☐	☐

Psychiatric:	Y	N
Do you have a history of psychiatric problems?	☐	☐
Are you subject to mood swings?	☐	☐
Are you under a lot of stress?	☐	☐

Endocrine:	Y	N
Do you urinate more frequently than before?	☐	☐
Are you excessively thirsty?	☐	☐
Do you have a history of bad breath?	☐	☐
Are you experiencing night sweats?	☐	☐
Do you have swollen glands?	☐	☐
Have you had a significant weight change recently?	☐	☐

Hematologic / Lymphatic	Y	N
Do you bruise easily?	☐	☐

Allergic / Immunologic:	Y	N
If you get cut, does it take a long time to heal?	☐	☐
Do you have allergic reactions to medication, foods dye?	☐	☐

J. Christopher Moore, DPM, AACFAS
Lily L. Moore, DPM, AACFAS

141 Asheland Ave., Suite 300
Asheville, NC 28801
Phone: 828-350-1880
Fax: 828-252-2272

Communication Permission Form

In order that we may serve you more efficiently, please fill out the following information.

I ______________________ give permission for Moore Foot & Ankle Specialists, PA to share my health information with the following people who are involved in my care:

Name	Relationship	Contact Number

____
Patient Print Name

______________________ ______________________
Patient Signature Date

Moore Foot & Ankle Specialists, PA
NOTICE OF PRIVACY PRACTICES

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.

Moore Foot & Ankle Specialists, PA is required, by law, to maintain the privacy and confidentiality of your protected health information and to provide our patients with notice of our legal duties and privacy practices with respect to your protected health information.

Disclosure of your Health Care Information

Treatment
We may disclose your health care information to other healthcare professionals within our practice for the purpose of treatment, payment or healthcare operations. (example)

> *"On occasion, it may be necessary to seek consultation regarding your condition from other health care providers associated with Moore Foot & Ankle Specialists, PA."*
>
> *"It is our policy to provide a substitute health care provider, authorized by Moore Foot & Ankle Specialists, PA, to provide assessment and/or treatment to our patients, without advanced notice, in the event of your primary health care provider's absence due to vacation, sickness, or other emergency situation."*

Payment
We may disclose your health information to your insurance provider for the purpose of payment or health care operations.

If payment is not made as arranged, our office may utilize an outside collection agency, credit reporting agency or other means of collecting outstanding debt. Your file, containing protected health care information, may be reviewed by the designated collection agency or authority.

Workers' Compensation
If applicable, we may disclose your health information as necessary to comply with state Workers' Compensation Laws.

Emergencies
We may disclose your health information to notify or assist in notifying a family member, or another person responsible for your care, about your medical condition or in the event of an emergency or of your death.

Public Health
As required by law, we may disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability; reporting child abuse or neglect; reporting domestic violence; reporting to the Food and Drug Administration problems with products and reactions to medications; and reporting disease or infection exposure.

Judicial and Administrative Proceedings
We may disclose your health information in the course of any administrative or judicial proceeding.

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Law Enforcement
We may disclose your health information to a law enforcement official for purposes such as identifying of locating a suspect, fugitive, material witness or missing person, complying with a court order or subpoena and other law enforcement purposes.

Deceased Persons
We may disclose your health information to coroners or medical examiners.

Organ Donation & Research
We may disclose your health information to organizations involved in procuring, banking or transplanting organs and tissues, or to researchers conducting research that has been approved by an Institutional Review Board

Public Safety
It may be necessary to disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or to the general public.

Specialized Government Agencies
We may disclose your health information for military, national security, prisoner and government benefits purposes.

Marketing and Other Communications
We may contact you for marketing purposes or fundraising purposes, as described below: (example)

> *"As a courtesy to our patients, it is our policy to call your home on the evening prior to your schedule appointment to remind you of your appointment time. If you are not at home, we leave a reminder message on your answering machine or with the person answering the phone. No protected health information will be disclosed during this call other than the date and time of your scheduled appointment and a request to call our office if you need to cancel or reschedule your appointment."*

> *"It is our practice to occasionally participate in charitable events. During these times, we may send you a letter, post card, invitation or call your home to invite you to participate in the charitable activity. We will inform you of the type of activity, the dates and times, and request your participation in such event. It is not our policy to disclose health information about you for the purpose of Moore Foot & Ankle Specialists, PA sponsored fund-raising events."*

Change of Ownership
In the event that *Moore Foot & Ankle Specialists, PA* is sold or merged with another organization, your health information/record will become the property of the new owner.

Your Health Information Rights

- You have the right to request restrictions on certain uses and disclosures of your health information. Please be advised, however, that Moore Foot & Ankle Specialists, PA is not required to agree to the restriction that you requested.
- You have the right to have your health information received or communicated through an alternative method or sent to an alternative location other than the usual method of communication or delivery, upon your request.
- You have the right to inspect and copy your health information.

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- You have a right to request that Moore Foot & Ankle Specialists, PA amend your protected health information. Please be advised, however, that Moore Foot & Ankle Specialists, PA is not required to agree to amend your protected health information. If your request to amend your health information has been denied, you will be provided with an explanation of our denial reason(s)and information about how you can disagree with the denial.

- You have a right to receive an accounting of disclosures of your protected health information made by Moore Foot & Ankle Specialists, PA.

- You have a right to a paper copy of this Notice of Privacy Practices at any time upon request.

Changes to this Notice of Privacy Practices

Moore Foot & Ankle Specialists, PA reserves the right to amend this Notice of Privacy Practices at any time in the future, and will make the new provisions effective for all information that it maintains. Until such amendment is made, Moore Foot & Ankle Specialists, PA is required by law to comply with this Notice.

Moore Foot & Ankle Specialists, PA is required by law to maintain the privacy of your health information and to provide you with notice of its legal duties and privacy practices with respect to your health information. If you have questions about any part of this notice or if you want more information about your privacy rights, please contact: Lily L. Moore, DPM & J. Christopher Moore, DPM by calling this office at 828-350-1880. If Lily L. Moore, DPM & J. Christopher Moore, DPM is not available, you may make an appointment for a personal conference in person or by telephone within 2 working days.

Complaints

Complaints about your privacy rights, or how Moore Foot & Ankle Specialists, PA has handled your health information should be directed to Lily L. Moore, DPM & J. Christopher Moore, DPM by calling this office at 828-350-1880. If Lily L. Moore, DPM & J. Christopher Moore, DPM is not available, you may make an appointment for a personal conference in person or by telephone within 2 working days.

If you are not satisfied with the manner in which this office handles your complaint, you may submit a formal complaint to:

DHHS, Office of Civil Rights
200 Independence Avenue, S.W.
Room 509F HHH Building
Washington, DC 20201

This notice is effective as of _01__/_01__/__2005___

I have read the Privacy Notice and understand my rights contained in the notice.

By way of my signature, I provide Moore Foot & Ankle Specialists, PA with my authorization and consent to use and disclosed my protected health care information for the purposes of treatment, payment and health care operations as described in the Privacy Notice.

____
Patient's Name (print)

______________________________ ______________
Patient's Signature Date

______________________________ ______________
Authorized Facility Signature Date

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE
MOORE FOOT & ANKLE SPECIALISTS, PA

As required by the Privacy Regulations, I hereby acknowledge that I have received a current copy of **Moore Foot & Ankle Specialists, PA's** "NOTICE OF PRIVACY PRACTICES", revision date _01-01-2005_.

As required by the Privacy Regulations, The Staff from **Moore Foot & Ankle Specialists, PA** has explained the "NOTICE OF PRIVACY PRACTICES" to my satisfaction.

As required by the Privacy Regulations, I am aware that **Moore Foot & Ankle Specialists, PA** has included a provision that it reserves the right to change the terms of its notice and to make the new notice provisions effective for all protected health information that it maintains.

Requests:

- ❑ I wish to file a "Request for Restriction" of my Protected Health Information.
- ❑ I wish to file a "Request for Alternative Communications" of my Protected Health Information.
- ❑ I wish to object to the following practices in the "Notice of Privacy Practices":

____

____

I understand that this office is not required to honor any changes to the "Notice of Privacy Practices".

______________________________ ____________
Signature Date

____
Print Name

____

(OFFICE USE ONLY)

Signed form received by: ______________________ Date: ________

The following effort was made to obtain receipt: (Describe)

____

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