PATIENT INFORMATION AND HISTORY

In order that we may better understand problems you may be having with your feet or legs, we must first know something about your health in general. Please answer as many of the following questions as possible. Thank you for your cooperation.

NAME: FIRST _____ MIDDLE _____ LAST _____

DATE OF BIRTH:_____ AGE _____ SEX: MALE / FEMALE HEIGHT_____ WEIGHT_____

HOW DID YOU FIND US? _____ ER referral _____ Family Doctor referral _____Insurance Directory _____Phonebook _____Newspaper
_____Family/Friend/Current or Previous Patient _____ Magazine Ad: Frisco Style Plano Profile Collin Quest _____ Radio

WHAT BRINGS YOU TO SEE US TODAY? _____
_____

NAME AND PHONE NUMBER OF PRIMARY CARE DOCTOR: _____

MEDICATIONS: What medications (and dosage) are you taking? **_____**
_____ **_____**
_____ **_____**

ALLERGIES: circle and give reaction you had.

Iodine _____ Penicillin _____ Pain medication _____ General Anesthetics _____
Local Anesthetics _____ Adhesive tape _____ Sulfa Drugs _____ Aspirin _____
Environmental Allergies: _____ Food Allergies: _____
Tell us anything not listed above that you are allergic to and your reaction._____
_____

PAST MEDICAL HISTORY: If you now have or have ever had any of the following conditions, please circle:

Diabetes	**Stroke**	**Skin problems**	**GastroIntestinal disorders**
Arthritis	**Rheumatism**	**Headaches**	**Ulcers**
Hepatitis	**Heart attack(s)**	**Glasses or contacts**	**Urinary disorders**
Thyroid problems	**Children/Pregnancies**	**HIV / AIDS**	**Bowel problems**
Gout	**Anemia**	**Asthma**	**Drug / Alcohol dependency**
Neuromuscular disease	**Bleeding problems**	**Eye disease**	**Depression**
High blood pressure	**Venereal disease**	**Hearing problems**	**Anxiety**
Cancer	**Blood Transfusion(s)**	**Circulation problems**	**Phlebitis**

FAMILY HISTORY (list any medical conditions that run in your family and member(s) it affects): _____
_____

HOSPITALIZATIONS / SURGERIES: List all hospitalizations and surgeries you have had. Begin with the most recent. Give month & year.
_____
_____
_____

SOCIAL HISTORY: circle or fill in all that apply

Married
Single
Divorced
Widowed

Alcohol intake: _____ **Caffeine intake: _____ cups/day**
Smoker: _____ pack(s)/day X _____ years **Recreational drug use: _____**
Retired? _____YES _____NO **If retired, please tell us your previous occupation below.**
Occupation:_____

Signature_____ **Date_____**

Patient _____
First Name Middle Initial Last Name Age

Birthdate_____/_____/_____ SS#_____/_____/_____ License#_____ State_____

Single ____ Married ____ Widowed____ Divorced ____ Separated ____

Address _____

City _____ State _____ Zip Code _____

Home Phone (_____) _____-_____ Work Phone (_____) _____-_____ Ext. _____

Employer _____ Occupation _____

(please circle) Patient or Guardian *(please circle)* Patient or Guardian

THE FOLLOWING SECTION MUST BE FILLED OUT FOR INSURANCE PURPOSES

Insurance Company _____ Policy #_____Group# _____

Insured's Name _____ SS# _____/_____/_____
First Name Middle Initial Last Name

Birthdate _____/_____/_____ Male _____ Female _____

Patient's Relationship to Insured: Self_____ Spouse_____ Child_____ Other_____

Insured's Address: Same as patient's_____ Other:_____

Insured's Phone number: Same as patient's_____ Other:_____
Home Work/Cell

Medicare: Yes_____ No _____ Medicaid: Yes_____ No_____

Nearest Relative/Friend_____(_____) _____-_____
First Name(s) Last Name Phone Number

AUTHORIZATION TO RELEASE PATIENT INFORMATION

I Authorize Robert P. Taylor, DPM to release and furnish on a confidential and strict need to know basis all medical and financial data related to my care that may be necessary now or in the future to facilitate payment by third parties for services rendered by physician, or to assist with, aid in, or facilitate the collection of data for purposes of utilization review, quality assurance, or medical outcomes evaluation purposes. Such information may be released to insurance companies, HMO's, and PPO's, managed care organizations, IPA's, Medicare/Medicaid or other governmental or third party payers, or any organizations contracting with any of the above entities to perform such functions.

Signature of Patient/Responsible Party _____ Date_____

PLEASE GIVE US YOUR INSURANCE CARD AND PHOTO ID

Robert P. Taylor, DPM

Fellow, American College of Foot & Ankle Surgeons
Diplomate, American Board of Podiatric Surgery

HIPPA 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.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment of health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

1. Uses and Disclosures of Protected Health Information

Uses and Disclosures of Protected Health Information
Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinated, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information as necessary, to a home health agency that provides care to you. For example, your protected health information may be provide to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For Example, we may disclose you protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Health issues as required by law, Communicable Diseases: Health Oversight Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers' Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures Will Be Made Only With Your Consent, Authorization or Opportunity to Object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights
Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records; Psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care of for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If your physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location.
You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints
You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against you for filing a complaint.**

This notice was published and becomes effective on/or before **April 14, 2003.**

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objection to this form, please ask to speak with our HIPPA Compliance Officer in person or by phone at our Main Phone Number.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices:

Patient Signature:_____ Date: _____

Printed Name: _____