New Patient Paperwork

WELCOME TO LOUISVILLE PODIATRY!

Please print and fill out these forms before your first visit, to save time.

Patient Information

Patient Name _____ (Last), _____ (First) _____ (Middle) SSN _____

Street _____ Birth Date _____ Age _____

City _____ Gender ☐ Male ☐ Female

State _____ Zip _____ Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Home Phone _____

Mobile Phone _____

Email Address _____ May we send email to this address? ☐ Yes ☐ No

Employer _____ Occupation/Position _____

Business Address _____ Business Phone _____

Spouse Name _____ Spouse Phone _____

Spouse Employer _____ Spouse Occupation _____

Business Address _____ Spouse Business Phone _____

Party Responsible for Payment of the Account (Please complete if other than the patient)

Name _____ Relation to Patient _____

Street _____ Employer _____

City _____ Occupation/Position _____

State _____ Zip _____ Business Address _____

Home Phone _____ Business Phone _____

Primary Insurance Information

Company _____

Subscriber Name _____

Date of Birth _____ SSN _____

Policy # _____ Group # _____

Secondary Insurance Information

Company _____

Subscriber Name _____

Date of Birth _____ SSN _____

Policy # _____ Group # _____

Other Information

Have you ever been seen by a Podiatrist? ☐ Yes ☐ No Podiatrist's Name _____

Emergency Contact Name _____ Emergency Phone _____

Nearest Relative Name _____

Nearest Relative Address _____ Phone _____

Whom may we thank for referring you to Louisville Podiatry? _____

2525 Bardstown Road • Louisville, KY 40205 • 502.458.8989 • Info@LouisvillePodiatry.com

New Patient Paperwork

Louisville Podiatry
Foot and Ankle Surgery

Patient Name: (please print) _____

Medical History (please check all that apply)

General Health: ☐ Excellent ☐ Good ☐ Fair ☐ Poor Shoe Size: _____ Width: _____

I have, have had or possess a family history of the following:

	YES	NO	Family History		YES	NO	Family History
Anemia	☐	☐	☐	Cardiovascular (Heart) Disease	☐	☐	☐
Arthritis	☐	☐	☐	Respiratory (Breathing) Problems	☐	☐	☐
Diabetes	☐	☐	☐	Gastrointestinal (Stomach) Distress	☐	☐	☐
Gout	☐	☐	☐	Urinary (Kidney) Problems	☐	☐	☐
Hypertension	☐	☐	☐	Bleeding Disorders	☐	☐	☐
Stroke	☐	☐	☐	Foot Problems	☐	☐	☐

Recent Glucose ____ A1C ____ (Please Specify) _____

Have you ever been treated for infectious disease (HIV, Hepatitis, MRSA, etc)? ☐ Yes ☐ No

Are you Pregnant? ☐ Yes ☐ No Ethnicity: _____ Primary Language: _____

What Medications are you taking? _____

_____

Medication Allergies _____ Other Allergies _____

_____ _____

Are there any other medical conditions we should be aware of? (specify) _____

Family Doctor _____ Pharmacy _____

Date Last Seen _____ Pharmacy Phone _____ Zip _____

Briefly describe your foot problem: _____

- I hereby request and give permission to Louisville Podiatry and whomever Louisville Podiatry may designate as assistants, to administer treatment, and to perform such general procedures as Louisville Podiatry may deem to be necessary In the diagnosis and/or treatment of my foot complaints.
- **AUTHORIZATION:** I hereby authorize the release of any medical information necessary to process my insurance. I authorize payment directly to the provider of services. I understand that I am financially responsible for any remaining or unpaid balances. I understand that interest will be applied to all accounts 60 days or more past due at a rate of 1 1/2% per month, annual rate of 18% and hereby agree to pay such charges. I understand that there will be a $30.00 fee applied to all returned checks.
- I further authorize the release of any medical information to other doctors treating me.
- I further authorize payment of Medicare and/or other insurance benefits to Louisville Podiatry for the services performed.
- I understand that payment for services at the time they are rendered is expected, unless specific and special arrangements are made prior to the appointment. A photostatic copy of these authorizations shall be as effective and valid as the original and shall remain In effect for one year following my last treatment.

_____ _____

Patient Signature Date and Time

_____ _____

Parent or Authorized Representative (if applicable) Relationship to Patient (if applicable)

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Louisville Podiatry
Foot and Ankle Surgery

Patient Name: (please print) _____

Consent for Treatment with Controlled Substances

1. **Controlled Substances**
   Certain controlled substances are prescribed to treat a variety of conditions, including the relief of moderate to severe pain. Pain relief is an important medical reason to take controlled substances. Controlled substances are drugs or chemical substances whose possession and use are regulated under the Controlled Substances Act. The law requires that patients are informed of such as Morphine, Demerol, Fentanyl, Codeine, Dilaudid, Oxycodone, Hydrocodone, Methadone, Vicodin, and Lortab.

2. **Adverse Effects**
   As with any medication, there are risks and adverse effects associated with the use of these controlled substances. Common adverse effects include, but are not limited to, sedation or sleepiness, nausea, vomiting, constipation, pruritus ("itching"), confusion, respiratory depression, and urinary retention. Some of these effects may make it unsafe for you to drive a vehicle, operate heave machinery, or perform other tasks that require concentration. Excessive use of these controlled substances can lead to profound sedation, respiratory depression, coma, and/or death.

3. **Physical Dependence, Tolerance and Addiction**
   Although uncommon when used for the treatment of acute pain, these controlled substances can cause physical dependence, tolerance and/or addiction when used for a prolonged period to treat chronic pain. Maintenance therapy with these controlled substances can cause physical dependence. This means that if these medications are abruptly stopped, or decreased significantly over a short period of time, a patient may experience withdrawal symptoms such as nervousness, irritability, insomnia, sweating, abdominal cramping, nausea, vomiting, and diarrhea. Tolerance occurs when the effects of these controlled substances are decreased over a period of prolonged use making it necessary to increase the dosage. Physical dependence and tolerance are different than addiction. Addiction is a complex disease characterized by compulsive craving or seeking and use of a substance despite its extreme negative effects on a person. The risk of addiction may be increased in a patient with a history of alcoholism or other addiction.

4. **Alternatives**
   These controlled substances are routinely prescribed to treat moderate to severe pain in patients. Other medicines are available to treat pain that are not associated with tolerance or addiction, however, are associated with a lower level of pain relief. It is also an alternative to not take any medicine to treat pain.

I, _____, ☐ Voluntarily Consent or ☐ Do Not Consent to the receipt of controlled substances (**If Needed**) for the treatment of pain and/or other symptoms as prescribed by Dr. Mauser (physician). I have been informed of the benefits, risks, and alternatives to taking these medications. I acknowledge that I have read and understand all of the information above and I have had the opportunity to ask questions and have them answered to my satisfaction.

_____ _____
Patient Signature Date and Time

_____ _____
Parent or Authorized Representative (if applicable) Witness

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Foot and Ankle Surgery

Patient Name: (please print) _____

Notice of Cancellation Policy

- I understand that I am responsible for my appointment time(s) and that should I not give notice of cancellation of my appointment at least **24 hours before** that appointment, I will be charged a **$25.00** fee.
- I understand that the **$25.00** fee will need to be paid in advance or at the time of my next appointment.
- I understand that the purpose of this policy is to allow any available appointment to be used by patients that need to be seen.

Access to Notice of Privacy Practices

- I acknowledge that I will be provided a copy of the Notice of Privacy Practices (if requested) and that I understand this notice. **This notice may be found at:** LouisvillePodiatry.com/nopp.pdf

Request for Confidential Communications

- I request that all communications (via telephone, mail or otherwise) to me or the person(s) designated below by Louisville Podiatry, PSC (or its staff) be handled in the following manner:

  _____

  _____

- For **written** communications, address to: _____

  _____

  _____

- For **oral** communications, call: _____
- May we leave a message? ☐ Yes ☐ No
- If the address provided above is **NOT** your home address, or is not a street address, please provide us with a street address for purposes of ensuring payment:

  _____

  _____

  _____

_____ _____
Patient Signature Date and Time

_____ _____
Parent or Authorized Representative (if applicable) Witness

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