New Patient Consultation Form

Name: Last_____**First**__**_____ MI**_____

Date of Birth: ____/____/____ **Age:**_____**Sex:** _____ **SSN:**_____

Race: ___White/Caucasian ___Black/African American ___Asian ___Hawaiian/Pacific Islander

___American Indian/Alaskan Native ___Declined ___Other

Ethnicity: ____Hispanic/Latino ____ Not Hispanic/Latino ____Declined

Patient Street Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Home Phone: _____ **Cell Phone:** _____

Employer: _____ **Work Phone:** _____

Primary Physician:_____ **Pharmacy:**_____

Emergency Contact: _____ **Phone:** _____

Insurance: _____ **Policy #:** _____

Secondary: _____ **Policy #:** _____

Email:_____

Current Problems: (Location, Duration, Onset, Course, Aggravating factors, previous treatment)

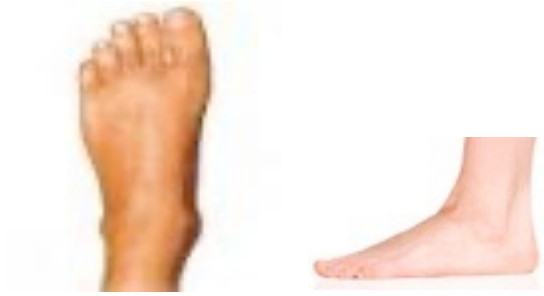
_____

_____

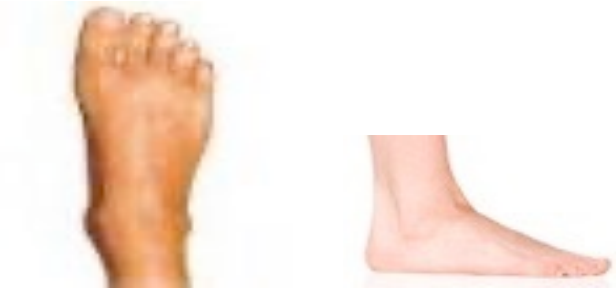
_____

Please use circles and arrows to indicate painful, injured, or problem areas:

Left foot:



Right foot:



Medical History

Height:_____ Weight:_____ Shoe Size:_____

Current Medications List:

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

Allergies: (Please include reaction)

_____

_____

_____

_____

Previous Injuries: **Previous Surgeries:** **Previous Hospitalizations:**

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

Social History:

Occupation:_____Marital Status:_____

Athletic Activities/Exercise:_____

Alcohol:_____ oz/day/week Tobacco:_____packs/day for _____ year

Personal and Family History

Check ✓ if personal, Circle if family has history of illness.

Major Disease:
___Diabetes
___Insulin
___Hypertension
___Angina
___Heart Disease
___Heart Attack
___Arrhythmia
___Mitral Valve Prolapse
___Stroke
___Chest Pain
___High Cholesterol

Vascular:
___Anemia
___Sickle Cell
___Bleeding Disorder
___Poor Circulation
___Night Cramps
___Leg Pain
___Spider Veins
___Varicose Veins
___Swelling
___Blood Clots
___Leg Ulcerations

Miscellaneous:
___Epilepsy
___Thyroid Disease
___Muscle Disease
___Kidney Problems
___Bladder Problems
___Prostate Problems
___Venereal Disease
___Skin Conditions
___Cancer History
___Hepatitis (A,B,C)

Respiratory:
__Asthma
___Bronchitis
__Frequent Colds
___Lung Disease
___Shortness of Breath
___Tuberculosis
___Emphysema

Gastrointestinal:
___Dyspepsia
___Stomach Ulcers
___Hiatal Hernia
___Acid Reflux
___Bowel Disorder
___GI/Rectal Bleeding

Psychological:
___Anxiety
___Depression
___Psych. Conditions
___Drug Dependence
___Alcoholism

HEENT:
___Headaches
___Eye Problems
___Hearing Problems

Arthritis:
___Osteoarthritis
___Rheumatoid
___Gout

Other:
_____
_____
_____

I hereby give my permission to Dr. Hilbert to administer treatment and to perform such procedures as may be deemed necessary for the treatment of my condition. I also hereby assign to the above physician all benefits provided by my insurance company policy for medical and surgical care. I understand that by accepting the services of Dr. Hilbert that I am incurring the financial responsibility under the terms of my insurance contract and/or for payment of services not covered by my insurance. I agree to inform his office prior to any treatment of any insurance changes or termination. I understand that failure to do this or failure to pay for services at the time that they are rendered will result in my being fully responsible for full payment of my medical bill along with any associated collection agency fees or interest/penalties. I understand that honest and complete answers to each question stated on this form are important to the provision of my medical care and I have answered to the best of my ability. I have been informed that if I have any questions, I should ask the staff of doctor for clarification.

_____ _____
Patient Signature Date

Coastal Podiatry
Paul Hilbert, DPM, FACFAS
7552 Navarre Pkwy. Unit 61
Navarre, FL 32566
Phone: 850-936-5226 Fax: 850-936-5254
Email: doctorhilbert@mediacombb.net

ACKNOWLEDGEMENTS

(Initial next to each acknowledgement, then sign and date below.)

Acknowledgement of Receipt of Notice of Privacy Practices

_____ I acknowledge that I was offered a copy of the Notice of Privacy Practices. I have read, or have had the opportunity to read, if I so choose, and understand the notice.

No Show Policy

_____ It is our goal to provide quality medical care to our patients in a timely manner. In order to accomplish this, we have to adhere to an appointment schedule. We understand that situations may arise that prevent you from coming in at the time of your scheduled appointment. In accordance with Coastal Podiatry's policy, we request that you notify us at least 24 hours in advance to reschedule or cancel your appointment. This allows us to manage our appointments more efficiently and to serve other patients that need to be seen. We reserve the right to charge a nominal fee of $35.00 for office visits and $100.00 for surgery appointments, if a patient does not provide adequate notice or fails to show up for their appointment. We will make an effort to contact you to remind you of your missed appointment and to reschedule and discuss the "No Show Fee" that will be applied to your account and payable at the next appointment. Patients that have three or more occurrences of repeated "No Shows" may be dismissed from our care. If you have any questions regarding this policy, please let us know. We kindly request that you sign the acknowledgment below stating that you have read and understand our policy as explained in this letter.

X-Ray Policy

_____Due to State and Federal Laws, all X-rays must be kept at our office. Your insurance pays for the service, not the films/images themselves. There is a fee of $20.00 to provide you with a digital image of each film in a disk format. Our policy is for you to give us 72 hours advanced notice that you would like a copy of your x-rays on disk.

Communication Consent

_____I give permission to Coastal Podiatry's staff to communicate with me by voice messaging, text messaging, and/or email. This form provides documentation of consent for this type of communication in compliance with the Telephone Consumer Protection Act (TCPA).

- This consent allows the staff to leave messages at the phone numbers provided in this paperwork.
- This provides prior expressed consent to receive automated voice and/or text messages at the phone numbers provided in this paperwork.
- I acknowledge that messages left may contain detailed information.
- This consent may be changed or revoked at any time. Requests must be made in writing.
- This consent does not expire.

Patient Printed Name_____ **Date**_____

Patient/Guardian Signature_____

Parent/Guardian Printed Name (if applicable)_____