NATCHEZ PODIATRY, PLLC

RICHARD A MYERS, JR., DPM

PATIENT REGISTRATION

Last Name: ____________________ MI _____ First Name: ________________________________

Date of Birth: ___/___/____ Social Security Number: ________________________________

Sex: M / F Age: ____ Weight: _____ Height: ____ft _____in Shoe Size _____

Marital Status: ( ) Single ( ) Married ( ) Widowed ( ) Divorced ( ) Partnered

Family Physician: ______________________________ Doctors Phone Number: ( ) ____-______

Date you last saw your family physician: ____

Pharmacy Name and Phone Number: ____

Employer: ______________________________________ Occupation: _______________________

Race/ Ethnicity: ( ) Asian ( ) African American ( ) Caucasian ( ) Hispanic ( ) Other

CONTACT INFORMATION

Address: ____

City: ____________________________ State: _________________ Zip Code: _________________

Home Phone: ( ) ___- ______ Work Phone: ( ) ___-____ Cell Phone: ( ) ___- ____ ______

E-Mail: ____

EMERGENCY CONTACT

Last Name: ________________________ MI: __ First Name: ______________________________

Home Phone: (___) ___-______ Work Phone: (___) ___-____ Cell Phone: (___) ___-________

Address: ____

City: _________________________ State: _________________ Zip: _________________________

Relationship to you: ____

Patient Name: ____ DOB: __________________

SOCIAL HISTORY

Do You? (Circle)

Smoke Tobacco   Chew Tobacco   Smoke Marijuana   Drink Alcohol   Use Illicit Drugs

If you use other recreational drugs please list or specify: ______________________________

If you drink alcohol please list the amount and frequency: __ Social   __ Moderate   __ Heavy

Do you drink the following: __ Wine __ Beer __ Liquor __ All Listed

Smoking Status (Circle)

Current Everyday Smoker   Current Someday Smoker   How long have you smoked __________

Former Smoker for How Long? ____________ or Never Smoked

EDUCATION (Circle)

Did No Complete High School   Completed High School   Some College   Completed College

Some Grad School   Masters Degree   Doctorate Degree

WOMEN ONLY

Are You Pregnant?   Yes   No

If you are pregnant, Number of Months: ___________ Expected Due Date: _______________

HAVE YOU EVER BEEN ANTICOAGULATED WITH ANY OF THE FOLLOWING BLOOD THINNERS

Coumadin (Warfarin)   Heparin   Aspirin   Plavix (Clopidogrel)   Eliquis   Brilinta   Xarelto

CURRENT MEDICATIONS

Please list all current medications below or if you have a list please give that to the front staff so we can scan this into your medial chart.

1. ______________________________
2. ______________________________
3. ______________________________
4. ______________________________
5. ______________________________
6. ______________________________
7. ______________________________
8. ______________________________
9. ______________________________
10. ______________________________

MEDICAL HISTORY

Please circle all that apply to you.

ILLNESS:

*Alcoholism

*Cancer

*Diabetes

*Elevated Cholesterol

*Hepatitis B

*Hepatitis C

*HIV/AIDS

*Hyperthyroidism

*Hypo (low) thyroid

*Liver Disease/Cirrhosis

*Lyme Disease

* Lymphoma

*Rheumatic Fever

CARDIAC:

*Angina

*Arrhythmia

*Atrial Fibrillation

*Congestive Heart Failure

*Cardia Arrest (heart attack)

*Coronary Artery Disease

*Fainting/Syncope

*Heart Murmur

*Heart Valve Replacement

*High Blood Pressure

*Low Blood Pressure

*Mitral Valve Prolapse

*Pacemaker/Defibrillator

VASCULAR:

*Blood Clots

*DVT (deep vein thrombosis)

*Greenfield filter

*Leg Swelling

*Leg ulcers

*Lymphedema

*Peripheral Artery Disease

*Phlebitis

*Poor Circulation

*Pulmonary Embolism

*Raynaud's

*Varicose Veins

* Vasculitis

BLOOD/HEMATOLOGIC

*Anemia

*Bleeding Disorder

*Hemophilia

*Leukemia

*Sickle Cell Disease or Trait

RESPIRATORY

*Asthma

*Bronchitis

*COPD

*Cystic Fibrosis

*Emphysema

*Pneumonia

*Sarcoidosis

*Sleep Apnea

*Tuberculosis

EENT

*Blindness

*Cataract

*Eye Disease

*Glaucoma

*Hearing Loss

*Macular Degeneration

*Migraine Headaches

*Nasal Polyps

*Tinnitus

GI (Gastrointestinal)

*Acid Reflux (GERD)

*Colitis

*Crohn's Disease

*Diverticulitis

*Duodenal Ulcer

*Gallbladder Disease

*Gastric By-Pass Surgery

*Gastric Ulcer

*Hemorrhoids

*Hiatal Hernia

*Ulcerative Colitis

*Irritable Bowel Disease

GU (Genitourinary)

*Bladder Infections

*Cystic Kidney Disease

*Kidney Infections

*Prostate Disease

*Renal Insufficiency

*Renal/Kidney Failure

*STD

*Syphilis

Musculoskeletal

*Achilles Tendonitis

*Amputation-Foot/Toes

*Amputation Leg

*Ankle Sprain

*Back Pain

*Bunion

*Bursitis

*Charcot Foot

*Club Foot

*Difficulty Walking

*Dislocation-Foot/Ankle

*Drop foot

*Fibromyalgia
*Foot Sprain

*Ankle Fracture

*Fracture-Leg

*Ganglion

*Gout

*Hammertoe

*Heel Spur
*Joint Instability

*Joint Stiffness

*Lupus (SLE)

*Muscle Spasm

*Osteoarthritis

*Osteoporosis

*Osteopenia

*Plantar fasciitis

*Psoriatic Arthritis

*Rheumatoid Arthritis

*Rupture-Achilles Tendon

*Shin Splints

*Tailor's Bunion

*Tendonitis, other

*Unequal Leg Length

Neuro/Psych

*Alzheimer's Disease
*Anorexia
*Anxiety Disorder
*Bi-Polar Disorder
*Brian Injury
*Cerebral Palsy
*Charcot Marie Tooth Disease
*Dementia
*Depression
*Diabetic Neuropathy
*Drug Dependency
*Epilepsy
*Hemiplegia
*Idiopathic Neuropathy
*Multiple Sclerosis
*Macular Dystrophy
*Pain Management
*Panic Disorder
*Paraplegia
*Parkinson's Disease
*Polio
*Poor Balance
*Ruptured Disc
*Schizophrenia
*Sciatica
*Seizure Disorder
*Spina Bifida
*Spinal Cord Injury
*Stroke
*TIA
*Tremors
*Vertigo

Skin

*Acne
*Athlete's Foot
*Contact Dermatitis
*Dermatitis
*Eczema
*Fungal Nail Infection
*Fungal Skin Infection
*Hyperkeratosis (corn or callus)
*Ingrown toenail
*Keloid/Scarring
*Malignant Melanoma
*Psoriasis
*Rash
*Scleroderma
*Skin Cancer
*Skin Disoder
*Warts
*Vitiligo

FAMILY HISTORY

Father—Does/Did Your Father Have?

Cancer High Blood Pressure CVA/Stroke Diabetes Heart Disease Kidney Disease

Any Other Illness: ______________________________

Is Your Father Deceased? Yes No

Mother—Does/Did Your Mother Have?

Cancer High Blood Pressure CVA/Stroke Diabetes Heart Disease Kidney Disease

Any Other Illness: ______________________________

Is Your Mother Deceased? Yes No

Siblings—Does/Did Your Siblings Have?

Cancer High Blood Pressure CVA/Stroke Diabetes Heart Disease Kidney Disease

Any other Illness: ______________________________

Are Your Siblings Deceased? Yes No

OTHER HEALTH INFORMATION

Flu Vaccine (this winter season): Yes No Date of Flu Vaccination: ____________________

Pneumonia Vaccine (done every 5 years): Yes No

Covid Vaccine: Yes No Dates of Covid Vaccination: ______________________________

SURGICAL HISTORY

Please check any surgery you have had in the past:

__ Eye Surgery (Cataract or Laser Surgery)

__Tonsillectomy

__Thyroid

__Appendectomy

__Pacemaker/Defibrillator

__Cardiac Stent

__Cardiac By-Pass Surgery

__Heart Valve Replacement

__Stent in Legs

__By-Pass Surgery on Legs

__Hernia

__Gallbladder

__C-Section

__Tubal Ligation

__Hysterectomy

__Breast Reduction

__Breast Biopsy or Removal of mass

__Mastectomy

__ Hip Replacement

__Knee Replacement

__Arthroscopic Knee Surgery

__Shoulder Rotator Cuff Surgery

__Carpal Tunnel Surgery

__Hernia Repair

__Toenail Surgery

__Bunion Surgery

__Hammertoe Surgery

__Fracture Repair

__Joint Fusion

__Tendon Repair

__Ankle Stabilization

__Back Surgery (Cervical Fusion or Lumbar Fusion)

__Prostate Surgery

__Skin Cancer Removal

DRUG ALLERGIES

NO KNOWN DRUG ALLERGIES

Check all that apply	**Yes**	**No**	**Reaction to Medication**
Penicillin, Ampicillin or Amoxicillin	__	__	____________________
Erythromycin	__	__	____________________
Sulfa or Bactrim	__	__	____________________
Kelfex	__	__	____________________
Tylenol	__	__	____________________
Aspirin	__	__	____________________
Ibuprofen or Motrin	__	__	____________________
Celebrex, Mobic or Meloxicam	__	__	____________________
Toradol or Tramadol	__	__	____________________
Morphine	__	__	____________________
Codeine, Hydrocodone or Oxycodone	__	__	____________________
Demerol	__	__	____________________
Novocaine	__	__	____________________
Shrimp, Iodine or IVP Dye	__	__	____________________
Adhesive Tape or Band Aids	__	__	____________________
Latex	__	__	____________________
Cortisone	__	__	____________________
Neosporin	__	__	____________________
Betadine	__	__	____________________

Possible reaction: Mild Moderate Severe

Skin rash Itching Hives Upset stomach Nausea Vomiting Diarrhea
Wheezing Difficulty Breathing Rapid Pulse Heart Palpitations Anaphylaxis

REVIEW OF SYSTEMS

CONSTITUTIONAL

*Fatigue

*Malaise

*Weight Loss

*Fever

*Body Aches

*Chills

*Night Sweats

*Loss of Appetite

EYES

*Discharge from eye

*Double Vision

*Eye Discomfort/Pain

*Impaired Vision

*Blurred Vision

*Changes In Vision

HEENT

*Headaches

*Nasal Discharge

*Recent Head Injury

*Sore Throat

*Nose Bleeding

*Dental or Gum Disease

*Lightheadedness

*Neck Stiffness

*Nasal Congestion

*Thyroid Mass
*Dentures

*Neck Pain
*Sinus Pain

CARDIOVASCULAR

*Chest Pain

*Syncope/Fainting

*Varicose Veins

*Pacemaker

*Defibrillator

*Irregular Heartbeat

*Shortness of Breath

*Edema in Legs

*Cardiac Arrest

*Slow Heartbeat
*Rapid Heartbeat

RESPIRATORY

*Shortness of Breath

*Pain with Breathing

*Painful Cough

*Productive Cough

*Difficulty Breathing

*Coughing up Blood

*Wheezing

GASTROINTSETINAL

*Nausea

*Constipation

*Blood in Stool

*Abdominal Pain

*Vomiting

*Gallstones

*Heartburn

*Black Stools

*Diarrhea
*Loss of Appetite
*Jaundice

*Eating Disorder

GENITOURINARY

*Urinary Frequency

*Possible Pregnancy

*Painful/Difficulty Urination

*Blood in Urine

*Kidney Stones

*Pelvic Pain

INTEGUMENT

*Rash

*Dry Skin

*Acne

*Itching

*Change/Loss of Hair

*Skin/Mole Changes

*Thick Nails

*Blisters

*Ingrown Nail

NEUROLOGIC

*Muscle Weakness

*Loss of Muscle Control

*Loss of Coordination

*Loss of Balance

*Numbness

*Tingling

*Tremors

*Seizures

*Dizziness

*Paralysis

*Difficulty with Speech

*Loss of Consciousness

*Loss of Sensation

*Memory Loss/Confusion

MUSCULOSKELETAL

*Muscle Weakness

*Joint Stiffness

*Joint Swelling

*Muscle Cramps

*Limitation of Motion

*Leg Swelling

*Instability

*Ankle Weakness

*Foot Pain

*Ankle Pain

*Knee Pain

*Leg Pain

*Hip Pain

*Joint Pain

ENDOCRINE

*Cold Intolerance

*Heat Intolerance

*Loss of Hair

*Weight Gain/Loss

PSYCHIATRIC

*Anxiety

*Depression

*Bi-polar Disorder

*Difficulty Sleeping

*Hallucinations

HEME-LYMPH

*Easy Bleeding

*Easy Bruising

*Enlarged Lymph Nodes

NATCHEZ PODIATRY, PLLC

RICHARD A MYERS, JR., DPM

CONSENT OF ASSIGNMENT OF BENEFITS AND TREATMENT

I certify that me or my dependents have insurance coverage with the named carrier on file and hereby authorize the release of all medical information necessary to process claim(s). I hereby assign and authorize direct payment of all medical and/or surgical benefits, including major medical, private insurance and other health plans to Natchez Podiatry, PLLC/Richard A Myers, Jr., DPM. The above named practice, its agents and assigns may use my health care information and may disclose such information to the named insurance company (companies) on file and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for relates services. I grant permission for the above named doctor and their assistants to render care in the diagnosis and or treatment of my foot conditions and release related information to my physician and or emergency medical personnel as required by law.

This assignment will remain in effect until revoked in writing. A signed photocopy of the assignment will be considered as valid as an original.

SIGNATURE OF RESPOONSIBLE PARTY **X**______________________________________ DATE___/___/______

PRINT NAME ____

PRINT NAME (IF DIFFERENT FROM RESPONSIBLE PARY) ____

ACKNOWLEDGEMENT OF RECEIPT OF FINANCIAL POLICY

I acknowledge that I have read and understand the financial policy. I understand that Natchez Podiatry, PLLC? Richard A Myers., Jr, DPM is not ultimately responsible for collecting form my insurance or negotiating settlement for claims.

I understand the financial policies and accept responsibility for payment of any balance owed on my account. I understand that I am responsible for all charges whether or not paid by insurance.

SIGNATURE OF RESPONSIBLE PARTY **X**______________________________________ DATE___/_____/_______

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Notice of Privacy Practices. I have read and understand the notice. By signing this form, I am consenting Natchez Podiatry, PLLC/Richard A Myers, Jr., DPM to disclosure of my Personal Health Information to carry out Treatment, Payment and healthcare operation.

SIGNATURE OF RESPONSIBLE PARTY **X**______________________________________ DATE____/____/_____

PRINT NAME ____

PATIENT NAME (IF DIFFERENT FROM RESPONSIBLE PARTY)____

FINANCIAL POLICY

As insurance coverage decreases and the patient's financial responsibilities increase, we understand the need for clear communication of our financial policies. To better service the needs of our patients, we have added valuable tools to help meet your increased medical expenses.

1. We will continue to look to insurance companies for their payment and assist you in receiving proper reimbursement for our services. Unfortunately, most insurance no longer cover services fully and most current insurance plans chosen by our patients require significant out-of-pocket expenses to be paid by the patient.
2. Our staff has been trained to be able to communicate with you and answer your questions regarding payment and insurance reimbursement.
3. It is your responsibility to verify that all requirements of your insurance plan are met. We will assist. You with pre-certification for procedures ordered by our office, but it is ultimately your responsibility to verify whether any care you receive is covered by your insurance plan. This office is not responsible for the expense of treatment or service, which is not paid for by your insurance. With continuous changes in coverage, it is important for you to verify your benefits and be aware of all restrictions and expenses of your plan.
4. In accordance with the requirements of most insurance contracts, we will require payment of office co-payments at the time of service. Any person being seen for treatment or service will be required to pay the necessary co-payment at the time of service. Your insurance company will be notified when this contractual payment is not paid at the time of the appointment.
5. For patients owed balances, we will offer credit cards, debit cards and payment plan to assist you in meeting your financial obligations to our office. You must advise us of any payment you receive from insurance or any third party for our services and forward this amount to our office immediately.
6. If we are a contracted provider on your insurance plan, we will file a claim with your carrier, and you will be billed when they have responded to our claim. Upon receipt of their response, payment or denial, you will receive a statement for the amount your insurance company notifies us is your responsibility.
7. If Natchez Podiatry, PLLC/Richard A Myers, Jr., DPM is not a contracted provider for tour insurance plan, we will file a claim with the information you provide and you will be billed when they have responded to our claim. You will receive monthly statements and we will look to you for payment. You will be responsible for working with your insurance company to ensure prompt payment.
8. If you do not have a current insurance card with you, you will be billed for the entire amount and asked for payment at the time of service. It is your responsibility to give us your card at each visit (if requested). We will not be able to file your insurance without a copy of your insurance card.
9. If you have an insurance plan that requires a referral, we will require that the referral be received in our office before we can see you. We will do our best to assist you in obtaining the referral, but to expedite matters it is best for you to contact your primary care physician and have them fax the referral over to us or bring the referral in with you.

NOTICE OF PRIVACY PRACTICES

I hereby give consent to Natchez Podiatry, PLLC/Richard A Myers, Jr., DPM to use and disclose PROTECTED HEALTH INFORMATION (PHI) about me to carry out treatment, payment and healthcare operations (TPO).

I have the right to review the NOTICE OF PRIVACY PRACTICES prior to signing the consent. Natchez Podiatry, PLLC/Richard A Myers, Jr., DPM reserves the right to revise its NOTICE OF PRIVACY PRACTICES at any time. A revised NOTICE OF PRIVACY PRACTICES may be obtained by forwarding a written request to Natchez Podiatry, PLLC at 151 Jeff Davis Blvd, Suite H Natchez, MS 39120.

With this consent, Natchez Podiatry, PLLC/Richard A Myers, Jr., DPM may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory results among others. However, our policy is not to leave detained messages regarding Protected Health Information, or anything related to treatment, payment or healthcare operation.

With consent, Natchez Podiatry, PLLC may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked Personal and Confidential.

With this consent, Natchez Podiatry, PLLC may email to my home or other alternative location any items that assist the practice in carrying out TPO., such as appointment reminder cards and patient statements. I have the right to request the Natchez Podiatry, PLLC restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement I may revoke my consent in writing except to the extent that the practice has already made disclosure in reliance upon my consent. If I do not sign this consent, or later revoke it, Natchez Podiatry, PLLC may decline to provide treatment.