Foot & Ankle Associates of Southern NH, PLLC

Dr. Drew Taft | Dr. Heidi Newkirk
6 Tsienneto Road, Suite 303, Derry, NH
603-432-2508

PATIENT INFORMATION

Patient's Name _____ Date: _____

First MI Last Home Phone:_____

Address_____ Cell Phone:_____

Street City Zip Work Phone:_____

Email: _____

___Married ___Single ___Separated ___Widowed

Age____ Date of Birth_____ Sex ___Male ___Female

Primary Pharmacy_____

Mail Order Pharmacy_____

Preferred Contact Number ___Home ___Work ___Cell

Primary Care Physician_____ Date Last Seen ___/___/___

Employer_____ Occupation_____

Employer's Address_____

Street City Zip

Emergency Contact_____Relationship_____Phone_____

PRIMARY INSURED (if self, do not complete the rest of this section)

___Self ___Spouse ___Parent ___Child ___Other

Name_____Home Phone_____

Address_____Cell Phone_____

Date of Birth___/___/___ Sex ___Male ___Female

Employer_____Occupation_____

Employer's Address_____

INSURANCE Primary Insurance Co_____Phone_____

Policy Holder's Name_____Policy #_____Group#_____

Secondary Insurance Co_____Phone_____

If other than self: Policy Holder's Name_____

Policy#_____Group#_____ Policy Holder's Date of Birth___/___/___

Patient Shoe Size_____ Height_____ Weight_____

REASON FOR TODAY'S VISIT? _____

Is this a work Injury? ___Yes ___No

Referring Doctor:_____ or Primary Care Physician:___

HOW DID YOU HEAR ABOUT THE PRACTICE? (circle one)

Internet/Google_____ Facebook_____

Friend/Family_____ Insurance Company_____

Doctor Referral (who?)_____ Other_____

PAST MEDICAL HISTORY

___Anemia
___Anxiety
___Arthritis
___Asthma
___Blood Clot
___Cancer(pls specify)
_____
___Congestive Heart Failure
___COPD/Breathing Problems
___Cataracts
___Dementia/Memory loss
___Depression
___Heart Disease
___Heartburn/Gastric Reflux
___Hepatitis
___High Cholesterol
___HIV
___Hypertension
___Kidney Disease
___Kidney Stones
___Leg/foot ulcers
___Liver Disease
___Osteoporosis
___Pneumonia
___Seizures
___Other
_____
_____

___Diabetes Year Diagnosed _____ Last HgA1C_____ Insulin___ Non-insulin___

CURRENT MEDICATIONS ___ None

_____ _____ _____

_____ _____ _____

ALLERGIES ___ No Known Drug Allergies

PRIOR SURGERIES ___ None

_____

_____

SOCIAL HISTORY

Do you smoke? ___ No, never smoked ___Yes, I have smoked for ___ years ___Yes, but quit ___ years ago

Do you drink alcohol? ___Yes, everyday(5-7drinks) ___Yes, occasionally/socially ___No/rarely

Substance abuse: ___No ___Yes(pls specify)_____

Are you pregnant ___Yes ___No

FAMILY HISTORY (please specify if parents or siblings had any of the following conditions)

___Diabetes ___Circulatory Problems ___Heart Disease ___Gout ___Blood Clots

___Hypertension ___Other:_____

REVIEW OF SYSTEMS (Please mark "x" if you have any of the following symptoms)

General	**Gastrointestinal**	**Neurological**
___Fever	___Abdominal pain	___Tingling/numbness
___Chills	___Nausea	___Seizures
___Fatigue	___Diarrhea	___Tremors
Cardiovascular	**Musculoskeletal**	**Endocrine**
___Leg pain when walking	___Muscle weakness	___Increased appetite
___Chest pain	___Joint pain	___Increased thirst
___Leg cramps	___Joint swelling	___Increased urination
Respiratory	**Skin**	**Allergy/Immunologic**
___Coughing	___Itchiness	___Hives
___Shortness of Breath	___Lower leg ulcers	___Itching
___Wheezing	___Rash	___Sinus pressure

Please read and sign: The above information is correct to the best of my knowledge. I understand that throughout my treatment at Foot & Ankle Associates of Southern NH, I am responsible for notifying the physician and/or medical staff of any and all updates to the information listed above.

_____ _____

Patient/Parent/Guardian **Date**

_____

_____

_____

_____

_____

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Patient Authorization

I hereby give my permission to the doctors of Foot & Ankle Associates of Southern NH, PLLC to perform diagnostic, therapeutic and/or operative procedures as may be deemed necessary in the diagnosis and/or treatment of my feet and ankles. I also request that payment of authorized Medicare or other insurance benefits be made directly to Foot & Ankle Associates of Southern NH, PLLC for any services furnished to me. I authorize any medical information about me to be released to the Health Care Financing Administration or other insurance regulators or agents and any information needed to determine those benefits or the benefits payable for related services. I give permission to Foot & Ankle Associates of Southern NH, PLLC to check my prescription eligibility and prescription history.

_____

Signature of Patient or Legal Representative Witness:

_____
Patient Name

_____
Date

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Consent to Obtain Patient Medication History

Patient medication history is a list of prescriptions that healthcare providers have prescribed for you. A variety of sources, including pharmacies and health insurers, contribute to the collection of this history.

The collected information is stored in the practice electronic medical record system and becomes part of your personal medical record. Medication history is very important in helping providers treat your symptoms and/or illness properly and avoid potentially dangerous drug interactions.

It is very important that you and your provider discuss all your medications in order to ensure that your recorded medication history is 100% accurate. Some pharmacies do not make prescription history information available, and your medication history might not include drugs purchased without using your health insurance.

Also, over-the-counter drugs, supplements, or herbal remedies that you take on your own may not be included.

I, _____, give my permission to allow Foot & Ankle Associates of Southern NH, PLLC to obtain my medication history from my pharmacy, my health plans, and my other healthcare providers.

_____
Signature of Patient or Legal Guardian

_____
Patient Name

_____
Date

By signing this consent form you are giving your healthcare provider permission to collect and share your pharmacy and your health insurer information about your prescriptions that have been filled at any pharmacy or covered by any health insurance plan. This includes prescription medicines to treat AIDS/HIV and medicines used to treat mental health issues such as depression.

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WAIVER OF INSURANCE

I, _____, will reimburse Foot & Ankle Associates of Southern NH for any charges that are not covered by my insurance carrier associated with my visits.

_____
Signature of Patient or Legal Representative Witness:

_____
Patient Name:

_____
Date:

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PHONE/EMAIL CONTACT CONSENT AND AUTHORIZATION

I, _____, with respect to any services provided or that are planned to be provided to myself or, as an authorized legal representative, for the below listed individual, fully consent to and authorize Foot & Ankle Associates of Southern NH, PLLC or any of its automated systems to contact me via phone (including to my cellular phone by way of phone call or text message) or email in relation to any services received from the physicians or any services planned to be received from the office (including any billing items or appointment reminders).

_____
Signature of Patient or Legal Representative Witness:

_____
Patient Name:

_____
Date:

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HIPAA

ACKNOWLEDGMENT OF RECEIPT of

NOTICE OF PRIVACY PRACTICES

I acknowledge that I have been shown a copy of the Notice of Privacy Practices and that I have had the opportunity to read if I so chose and understood the Notice.

_____
Signature of Patient or Legal Representative Witness:

_____
Patient Name:

_____
Date:

Please be advised that if you choose not to or refuse to sign the Waiver of Insurance or the Acknowledgement of Receipt of Notice of Privacy Practices (HIPAA), we must refuse treatment.

Sorry for any inconvenience.