RICHMOND PREMIER FOOT & ANKLE CLINIC

PATIENT DEMOGRAPHIC

First name ____________ Middle name ____________ Last name ____________

Date of Birth ____________ Age ____________ Phone # ____________ Alternate phone # ____________

Email ____________ Home Address ____________

Height ____________ Weight ____________ Shoe size ____________

Primary Insurance ____________ Primary insurance member ID # ____________

Secondary insurance ____________ Secondary insurance member ID # ____________

Primary care physician name ____________ Phone # ____________ Last visit date ____________

Pharmacy name ____________ Phone number ____________ Location ____________

CHIEF COMPLAINTS

Why are you here? ____________

How long have you experienced this issue? ____________

Have you sought treatment from another physician? ____________ If "yes", what? ____________

Is there anything that helps? ____________ If "yes", what? ____________

What hurts?	☐ left foot	☐ left ankle	☐ right foot	☐ right ankle	☐ toenail	☐ Other	☐ I'm not in pain

Nature of pain	☐ throbbing	☐ sharp/stabbing	☐ radiating/burning	☐ I'm not in pain

How did you hear about us? ____________

MEDICAL HISTORY (e.g. cancer, diabetes, etc...)	SURGICAL HISTORY (e.g. back surgery, gallbladder, etc...)	ALLERGIES (e.g. drugs, seasonal, etc....)	CURRENT MEDICATIONS

SOCIAL HISTORY

	Yes	No
Married	☐	☐
Children	☐	☐
Pregnant or planning	☐	☐
Smoker	☐	☐
Drinker	☐	☐

Occupation ____________

Company ____________

FAMILY HISTORY (this section applies to any members of your family)

	Yes	No		Yes	No
Diabetes	☐	☐	Rheumatological Disorder	☐	☐
High blood pressure	☐	☐	Bleeding disorder	☐	☐
Heart disease	☐	☐	Kidney disease	☐	☐
Stroke	☐	☐	Mental illness	☐	☐
Cancer	☐	☐			

PROBLEMS EXPERIENCED WITHIN THE LAST 30 DAYS (check the box)							
General	☐ Nausea	☐ Vomiting	☐ Fever	☐ Chills	☐ Night sweats	☐ Weight Loss/gain	☐ None
Heent	☐ Headache	☐ Visual changes	☐ Sinus pain	☐ Hard of hearing	☐ Difficulty swallowing		☐ None
Cardiovascular	☐ Chest pain	☐ Shortness of breath	☐ Palpitation	☐ Edema			☐ None
Respiratory	☐ Cough	☐ Sputum	☐ Shortness of breath	☐ Wheezing			☐ None
Gastrointestinal	☐ Abdominal pain	☐ Difficulty swallowing	☐ Diarrhea	☐ Constipation			☐ None
Genitourinary	☐ Painful urination	☐ Frequent urination	☐ Bloody urine	☐ Vaginal discharge			☐ None
Musculoskeletal	☐ Pain	☐ Joint swelling	☐ Stiffness	☐ Functional deficit	☐ Arthritis		☐ None
Dermatological	☐ Rash	☐ Skin lesion	☐ Open wound	☐ Mass/lump			☐ None
Neuro	☐ Numbness	☐ Tingling	☐ Pins-and-needles	☐ Limb weakness	☐ Poor balance		☐ None
Psychiatric	☐ Depression	☐ Anxiety	☐ Lack of energy				☐ None
Hematological	☐ Easy bleeding	☐ Easy bruising					☐ None

Please use the space below to explain in further details if you checked any of the above

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Patient Signature ____________________ Date ____________

Parent/Guardian Signature ____________________ Date ____________

Doctor Signature ____________________ Date ____________

Summary of Notice of Privacy Practices

The following summary outlines how our practice will protect your health information, your rights as a patient and our common practices in dealing with your health information.

Uses and Disclosures Based on Your Authorization. Except as stated in more detail in the Notice of Privacy Practices, we will not use or disclose your health information without written authorization.

Uses and Disclosures of Health Information. We will use and disclose your health information in order to treat you or to assist other health care providers in treating you. We will also use and disclose your information in order to obtain payment for our services or to allow insurance companies to process claims for services rendered to you by us or other healthcare providers. Finally we may disclose health information for certain limited operational activities such as quality assessment, licensing, accreditation and training of students.

Uses and Disclosures Not Requiring Your Authorization.
In the following circumstances, we may disclose your health information without your written authorization.

- To family members or close friends who are involved in your healthcare
- For certain limited research purposes
- For purposes of Public Health and safety
- To Government agencies for purposes of their audits, investigations and other oversight activities.
- To government authorities to prevent child abuse or domestic violence
- To Law enforcement authorities to protect public safety or to assist in apprehending criminal offenders
- When required by court orders, search warrants, subpoenas and as others required by Law.

Patient Rights. As our patient, you have the following rights.

- To have access to and/or copy of your health information
- To receive an accounting of certain disclosures we have made of your health information
- To request restrictions as how your health information is used or disclosed
- To request that we communicate with you in confidence
- To receive notice of our privacy policies

If you have a question, concern or complaint regarding our privacy practices, please submit your concerns in writing to:

Dr. Seyi Jennifer Oteri, DPM
Podiatric Medicine and Surgery
Phone: (832) 449-3520
Email: richmondpremierfootankle@gmail.com

	Yes	No
May we email, phone, or text you to confirm appointments, or leave voicemail on your home/cell phone	❑	❑
May we provide your health information via your email provided?	❑	❑
May we use any pictures if taken for advertisement or educational purposes only? (your face will not appear on them)	❑	❑
May we discuss your medical condition with a family member? If yes, provide name & phone number	❑	❑

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Patient Name	Signature	Date
Parent/Guardian Name	Signature	Date