

Account #: _____
(office use only)

Patient Information Sheet

Southern Ohio Foot and Ankle Associates, Inc.
John F. Boyle, D.P.M.

1130 Western Avenue
Chillicothe, Ohio 45601

1235 South Court Street
Circleville, Ohio 43113

Patient Name _____ Date _____
Last First MI

Address _____

City _____ State _____ Zip _____

Telephone (____) _____ Cell Phone (____) _____ Work Phone (____) _____

Date of Birth ____/____/____ Sex () Male () Female Social Security # _____ - _____ - _____

Marital Status () Married () Single () Other

Are You a Student? () Full Time () Part Time () Not a Student

E-Mail address _____

Would you like to receive e-reminders for appointments? () Yes () No

Your Employer _____

Address _____ City _____ State _____ Zip Code _____

Occupation _____ () Full Time () Part Time () Not Employed

Guarantor if covered under spouse's insurance OR a minor:

Name: _____ Date of Birth ____/____/____

Address _____ City _____ State _____ Zip Code _____

Social Security # _____ - _____ - _____ Relationship to Patient _____

Guarantor's Employer _____ Phone (____) _____

EMERGENCY CONTACT: _____ Phone (____) _____

Relationship to Patient _____

How did you hear about our office?

- () Doctor Referral () Family Member () Newspaper Ad () Radio Ad
- () Emergency Room () Adena Regional Medical Center () Friend
- () Co-Worker () Insurance () Newsletter () Know an Employee Here
- () Internet Web Site () Other – Please list _____

Medical History

Name _____ Today's Date ____/____/____

Date of Birth ____/____/____ Height _____

Shoe Size _____ Weight _____

Reason for today's visit _____

Primary Care Physician _____ Date of last visit ____/____/____

Address of Physician _____

Physician's phone number _____

Pharmacy _____ Address _____

Pharmacy phone number _____

Have you seen a cardiologist? ()Yes ()No Dr _____

Do you, or have you, had any of the following conditions:

Please check all that apply

- | | |
|---------------------------------|----------------------------------|
| () Diabetes | () Arthritis |
| Since what age _____ | () Rheumatoid Arthritis |
| Do you take | () Raynauds Syndrome |
| () Insulin () Pills | () Depression |
| () Family History of Diabetes | () History of Rheumatic Fever |
| () Breathing Problems | () Peripheral Vascular Disease |
| () Heart Problems | (Circulatory Problems) |
| () Stomach Problems | if yes due to |
| () High Blood Pressure | _____ |
| () Abnormal Bleeding | |
| () Fainting Spells/Seizures | () Do you Smoke |
| () T.B./Pneumonia | How many years _____ |
| () Liver problems or Hepatitis | Packs per Day _____ |
| () Kidney Disorders | () Use Alcohol |
| () Cancer | () Use Recreational Drugs |
| Where _____ | () Other diseases or Conditions |
| When _____ | _____ |

Please list any past surgeries and include dates

Chart # _____

(office use only)

Name _____

Date of Birth ____/____/____

Medications and Allergies

Please List All Current Medications and Dosage

| | |
|-------|-------|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

Please List Any Allergies

If you do not have any known allergies, please write NONE

Release of Information

Please list below any person(s) you would like to release your medical information to. This may include family members, physicians, or any entity you wish to disclose your individual identifiable information to. **Please note if no person(s) are listed we cannot release any of your information.**

| | |
|-------|-------|
| _____ | _____ |
| _____ | _____ |

I hereby instruct and direct that any and all payment (ins. Companies, collection agencies, ect.), be made directly to Southern Ohio Foot and Ankle Associates, Inc. (SOFAA). I am also releasing all medical records, if needed, to receive payment. I authorize SOFAA to deposit checks received for my account when made out to me. I also authorize the release of any information pertinent to my case to any insurance co., physician, hospital, adjuster, or attorney involved in this case.

In Medicare assigned cases and in-network insurances, we will bill and accept the allowable charge, and the patient is responsible for deductibles, co-insurance/co-payments, and non-covered services.

Out-of-Network insurances will be billed as a courtesy to you. The patient is responsible for services not paid by the insurance company.

If you fail to pay these charges, we may turn your account over to a collections agency, and will add a 30% interest charge to your account.

By signing this, I understand and agree.

I have read all the information on the previous pages and have completed all answers.
I certify the information on all pages is correct and true to the best of my knowledge.
I will notify you of any changes in my status, or changes of the previous information.

Signed _____ **Date** _____

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT

Southern Ohio Foot and Ankle Associates, Inc.
1130 Western Avenue, Chillicothe OH 4501
1235 South Court Street, Circleville OH 43113
740-775-7800

I understand that, under the Health Insurance Portability & Accountability act of 1996 (HIPPA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment, directly and indirectly.
- Obtain payment from third party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or healthcare operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name _____

Parent or Authorized Representative _____
(If applicable)

Signature _____

Date _____

Office Use Only

I attempted to obtain the patient’s signature in acknowledgement on this *Notice of Privacy Practices Acknowledgement*, but was unable to do so as documented below:

Date: _____

Initials: _____

Reason: _____