WHITE SANDS PODIATRY
FOOT AND ANKLE SURGERY CENTER

Patient Information Form

Patient Name_____ Date of Birth:____/____/____
(Last) (First) (MI)

Home Address:_____City/State_____Zip:_____

Home #:_____Work #:_____Cell #:_____

Email:_____SSN:_____

Marital Status:_____ Age:_____ Sex: M F

Legal Guardian (POA):_____Relationship:_____Phone:_____

Emergency Contact:_____ Relationship:_____Phone:_____

Insurance Provider:_____

****Primary Care Doctor**:_____ Location:_____ Phone:_____

Pharmacy:_____Location:_____ Phone:_____

Who is responsible for payment?_____Relationship:_____

Who referred you to us?_____

Do you have an advanced care directive/living will? Yes No (circle one)

If yes, who is responsible for your medical decisions?_____

Allergies:

Medication Allergies:_____

Food Allergies:_____

Other Allergies (ex. latex, adhesive, anesthesia):_____

___No Known Allergies

Your Medical History: Weight:_____lbs Height:_____

Patient Name:_____ Date of Birth:_____/_____/_____

Please List **ALL MEDICATIONS** you are currently taking (including prescription, over the counter, and herbal medications): You can attach on a separate sheet.

Name	Dose	Name	Dose

Please list **ALL prior Surgeries**: You can attach on a separate sheet.

Type of Surgery	Date	Type of Surgery	Date

Social History:

Alcohol: ___Never ___No longer use ___Rare ___Occasional ___Moderate ___Daily
___History of Abuse

Tobacco: ___Never ___No longer use ___Rare ___Occasional ___Moderate ___Daily
Type:_____

Recreational Drugs:
___Never ___No longer use ___Rare ___Occasional ___Moderate ___Daily
Type:_____

Family History: Type

Heart Disease
Maternal or Paternal? (circle one/both)_____

Diabetes
Maternal or Paternal? (circle one/both)_____

Cancer/Other
Maternal or Paternal? (circle one/both)_____

Patient Name:_____ Date of Birth:_____/_____/_____

How much are you on your feet at work? ___10% ___25% ___50% ___75% ___100%

Have you ever had any of the following?: (please circle)

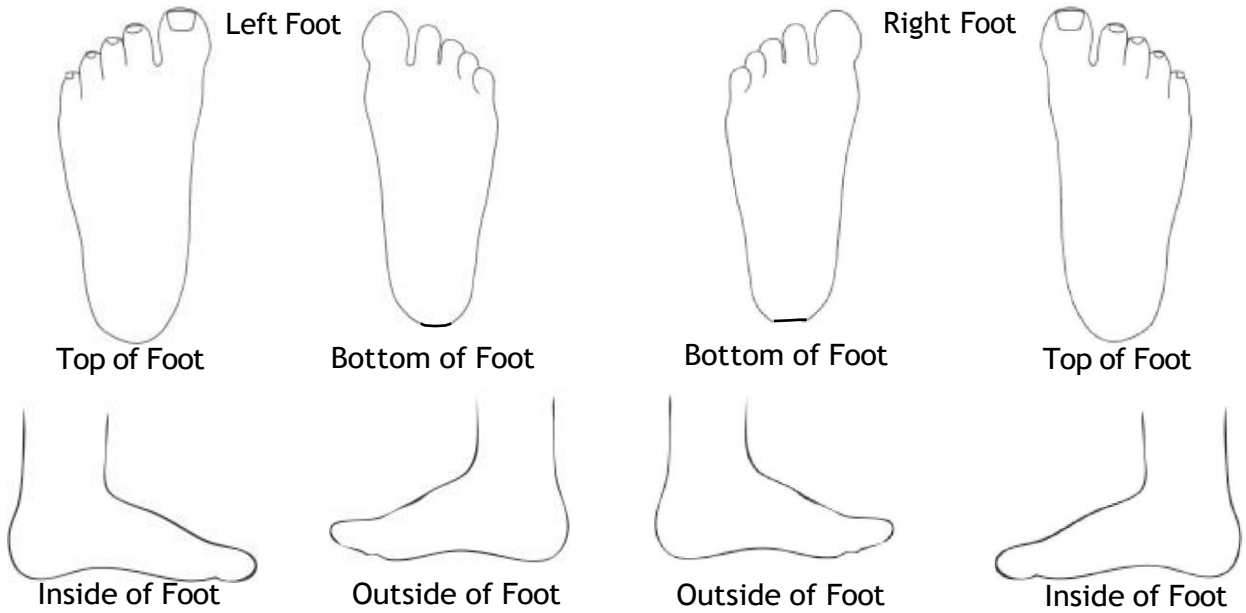
Acid Reflux	Fibromyalgia	Mitral Valve Prolapse
Anemia	Gout	Neuropathy
Arthritis	Heart Attack	Open Sores
Asthma	Heart Disease / Failure	Pneumonia
Back Trouble	Hepatitis	Rheumatic Fever
Bladder Infections	HIV / AIDS	Sickle Cell Disease
Abnormal Bleeding	High Blood Pressure	Skin Disorder
Blood Clots	High Cholesterol	Sleep Apnea
Blood Trasfusion	Kidney Disease	Stomach Ulcers
Bronchitis / Emphysema	Liver Disease	Stroke
Cancer	Low Blood Pressure	Thyroid Disease
Diabetes	Migraine Headaches	Tuberculosis

Other Conditions: _____

CURRENT PROBLEM:

What specific problem brings you into our office today?_____

Where is the pain? (please mark below) How bad is the pain? _____



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TO THE BEST OF MY KNOWLEDGE, I HAVE ANSWERED THE QUESTIONS ON THIS FORM ACCURATELY. I UNDERSTAND THAT PROVIDING INCORRECT INFORMATION CAN BE DANGEROUS TO MY HEALTH. I UNDERSTAND THAT IT IS MY RESPONSIBILITY TO INFORM THE DOCTOR AND OFFICE STAFF OF ANY CHANGES IN MY MEDICAL STATUS.

I, the undersigned assign directly to Sean Hodson, DPM all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I understand that every possible effort will be made to collect outstanding financial responsibilities. I understand that failure to pay outstanding charges will be reported to our collection agency. I understand that this document authorizes treatment and hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.
By signing below, you state that you have read and understand above.
These forms must be signed by parent/guardian if patient is a minor.

_____
Print Name of Patient

_____
Signature of Patient or Parent/Guardian

_____
Date

WHITE SANDS
PODIATRY
FOOT AND ANKLE SURGERY CENTER

SEAN HODSON, DPM — PHONE: 850-622-1607 — FAX: 888-302-6552

CONSENT FOR PURPOSES OF TREATMENT, PAYMENT, AND HEALTHCARE OPERATIONS

I consent to the use or disclosure of my protected health information by White Sands Podiatry for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills, or to conduct health care operations of White Sands Podiatry. I understand that diagnosis or treatment of me by Dr. Sean Hodson may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment, or healthcare operations of the practice. White Sands Podiatry is required to agree to the restrictions that I may request. However, if White Sands Podiatry agrees to a restriction request, the restriction is binding on White Sands Podiatry and Dr Sean Hodson.

I have the right to revoke this content, in writing, at any time, except in the extent that Dr Sean Hodson or White Sands Podiatry has taken action in reliance of this consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer, or a health care clearinghouse. This protected health information relates to my past, present, or future physical or mental health condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have the right to review White Sands Podiatry's HIPAA policy prior to signing this document.

These forms must be signed by parent/guardian if patient is a minor.

_____ _____

Signature of Patient or Parent/Guardian Date

_____

Print Name of Patient

WHITE SANDS
PODIATRY
FOOT AND ANKLE SURGERY CENTER

Dr. Sean C. Hodson, AACFAS
Ph: (850) 622-1607 Fax: (888) 302-6552

Authorization to Release Medical Records

DATE: _____

Patient Information:

Name:_____ DOB:_____

Authorized Representative* making request (if other than patient): _____

(Relation to patient): _____

Request records from:

*I hereby authorize the release of all my medical records/documentation from the following:

Provider: _____ **Phone**: _____

Provider: _____ **Phone**: _____

Provider: _____ **Phone**: _____

Information to be released:
*All, unless otherwise specified

Request records be sent to:

White Sands Podiatry, Dr. Sean C. Hodson
981 US Hwy 98 East, Destin FL, 32541
Phone: (850) 622-1607 Fax: (888) 302-6552

**There are times during a patient's course of treatment that it becomes essential to request records from other medical providers. We will keep this form on file in your chart.

Authorized Signature: _____ **Date:** _____