

PERSONAL INFORMATION

Patient Name: First _____ Middle _____ Last _____

Sex: Male Female Social Security Number (Last 4 only) _____

Date of Birth ____/____/____ Age: _____ Email _____

Address: _____

City _____ State _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Work Phone : _____

Primary Care Physician: Doctor Name: _____ Practice Name: _____

Primary Language: _____ Do you need an Interpreter? Yes / No

Race: American Indian Asian Black/ African American White Native Hawaiian/ Other

Ethnicity: Non-Hispanic/Latino Hispanic/ Latino

How did you hear about our office?

Direct Mailing Friend Insurance Company Internet Newspaper Another Patient Doctor/HealthCare Provider Other

Name of referral source: _____

Emergency Contact: Name: _____ Phone: _____

Referring Provider: Doctor Name: _____ Practice Name: _____

Marital Status: Divorced Married Partner Single Unknown/ Other Widowed Legally Separated

Name of spouse/partner/nearest relative: _____ Phone # _____

Are you a student: Yes, Part time Yes, Full Time No, not Currently a Student

Are you employed? Yes, Part Time Yes, Full Time No, Not Currently Employed

Employer (Company Name): _____ Occupation: _____

How may we contact you: Phone Mail E-mail Is it ok to leave a message? Yes No

Other Physicians Currently Treating you:

Physician: _____ Phone: _____ Reason: _____

Physician: _____ Phone: _____ Reason: _____

Physician: _____ Phone: _____ Reason: _____

May we contact your physician(s) regarding your health / treatment to insure your health and safety? Yes No

Pharmacy Name: _____ Location: _____

Phone Number: _____ *This information is mandatory; We use Surescripts for all Prescriptions

PATIENT MEDICAL HISTORY

Please Complete ALL Medical History

Family Medical History

Have any of your blood relatives been diagnosed with the following conditions?

- | | | |
|--|--|---|
| Y N | Y N | Y N |
| <input type="checkbox"/> <input type="checkbox"/> Arthritis | <input type="checkbox"/> <input type="checkbox"/> Stroke | <input type="checkbox"/> <input type="checkbox"/> Hammer Toes |
| <input type="checkbox"/> <input type="checkbox"/> Heart Disease | <input type="checkbox"/> <input type="checkbox"/> Diabetes | <input type="checkbox"/> <input type="checkbox"/> Cancer |
| <input type="checkbox"/> <input type="checkbox"/> Bunions | <input type="checkbox"/> <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> <input type="checkbox"/> Type _____ |
| <input type="checkbox"/> <input type="checkbox"/> Heel Spurs | <input type="checkbox"/> <input type="checkbox"/> Breathing Problems | <input type="checkbox"/> <input type="checkbox"/> Nerve Disorders |
| <input type="checkbox"/> <input type="checkbox"/> Circulation Problems | <input type="checkbox"/> <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> <input type="checkbox"/> Sickle Cell | <input type="checkbox"/> <input type="checkbox"/> Flat Feet | |
| | <input type="checkbox"/> <input type="checkbox"/> Liver Disease | |

Personal Medical History

Please list any drug allergies and the reaction you experienced:

Are you sensitive to Tapes or Adhesives? Yes No

Do you have any problems taking Aspirin or Ibuprofen (Aleve, Motrin, Advil)? Yes No

Describe: _____

Please list all medications and herbal supplements that you are currently taking:

Are all of your immunizations up to date Yes No Have you had a current flu shot? Yes No

Current Height _____ Current Weight _____ Shoe Size _____

Past Medical History

Please check if you have been diagnosed with any of the following conditions:

Constitutional

- | | | |
|--|---|---|
| Y N | Y N | Y N |
| <input type="checkbox"/> <input type="checkbox"/> Anxiety | <input type="checkbox"/> <input type="checkbox"/> Convulsions | <input type="checkbox"/> <input type="checkbox"/> Headache/Migraine |
| <input type="checkbox"/> <input type="checkbox"/> Appetite Changes | <input type="checkbox"/> <input type="checkbox"/> Dementia | <input type="checkbox"/> <input type="checkbox"/> Sleep Problems |
| <input type="checkbox"/> <input type="checkbox"/> Bi-Polar | <input type="checkbox"/> <input type="checkbox"/> Depression | <input type="checkbox"/> <input type="checkbox"/> Mental Disease |
| <input type="checkbox"/> <input type="checkbox"/> Dizziness | <input type="checkbox"/> <input type="checkbox"/> Syncope | <input type="checkbox"/> <input type="checkbox"/> Vertigo |

Cardiovascular

- | | |
|--|---|
| Y N | Y N |
| <input type="checkbox"/> <input type="checkbox"/> Aortic Aneurysm | <input type="checkbox"/> <input type="checkbox"/> High Cholesterol |
| <input type="checkbox"/> <input type="checkbox"/> Angina (Chest Pain) | <input type="checkbox"/> <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> <input type="checkbox"/> Valve Disorders | <input type="checkbox"/> <input type="checkbox"/> Heart Murmur |
| <input type="checkbox"/> <input type="checkbox"/> Heart Rhythm Disorders | <input type="checkbox"/> <input type="checkbox"/> Circulation Problems |
| <input type="checkbox"/> <input type="checkbox"/> Blood Clot | <input type="checkbox"/> <input type="checkbox"/> Palpitations |
| <input type="checkbox"/> <input type="checkbox"/> Congestive Heart Failure (CHF) | <input type="checkbox"/> <input type="checkbox"/> Stroke |
| <input type="checkbox"/> <input type="checkbox"/> Coronary Artery Disease (CAD) | <input type="checkbox"/> <input type="checkbox"/> Cardiomyopathy |
| <input type="checkbox"/> <input type="checkbox"/> Irregular Heart Beat | <input type="checkbox"/> <input type="checkbox"/> Peripheral Vascular Disease |
| <input type="checkbox"/> <input type="checkbox"/> Heart Attack | <input type="checkbox"/> <input type="checkbox"/> Other _____ |

Dermatologic

Y N

- Eczema
- Rash
- Hives

Y N

- Ulcers
- Warts
- Hypersensitivity of Skin

Y N

- Itchy Skin/Scalp
- Non-Healing Wound
- Psoriasis

Endocrine

Y N

- Diabetes
- Hypoglycemia

Y N

- Hyperglycemia
- Hypothyroidism

Y N

- Hyperthyroidism
- Hormone Imbalance

Gastrointestinal

Y N

- Acid Reflux (GERD)
- Gallbladder Problems
- Blood in Stool
- Cirrhosis

Y N

- Liver Problems
- Hepatitis
Type? _____
- Diverticulitis
- IBS

Y N

- Stomach Ulcers
- Hernia
- Colon Problems
- Crohns Disease

Genitourinary

Y N

- Kidney Stones
- Kidney Problems
- Bladder Disease

Y N

- Dialysis
- Blood in Urine
- Prostate Disease

Y N

- (UTI)
- Incontinence
- STD

Gynecologic

Y N

- Breast Cancer
- Cervical Cancer

Y N

- Endometriosis
- C-Section

Y N

- Hysterectomy
- Other _____

Musculoskeletal

Y N

- Arthritis
- Bone Spurs
- Bursitis
- Carpal Tunnel
- Charcot

Y N

- Fibromyalgia
- Disk Problems
- Osteoarthritis
- Osteopenia
- Osteoporosis

Y N

- Rheumatoid Arthritis
- Scoliosis
- Sciatica
- Spinal Stenosis
- Tendonitis

Neurological

Y N

- Stroke (CVA)
- Multiple Sclerosis

Y N

- Paralysis
- Seizures

Y N

- Tremors
- Neuropathy

Respiratory

Y N

- Asthma
- COPD

Y N

- Emphysema
- Sleep Apnea

Y N

- Tuberculosis
- Sinusitis

Immunologic

Y N

- Hay Fever
- Seasonal Allergies

Y N

- Shingles
- HIV/AIDS

Y N

- Rheumatic Fever
- Iodine Allergy

EENT

Y N
 Double Vision
 Hearing Loss

Y N
 Glaucoma
 Blindness

Y N
 Ringing in the Ears
 Sinusitis

Hematologic

Y N
 Anemia
 Bleeding Tendencies

Y N
 Sickle Cell Trait
 Swollen Lymph Nodes

Y N
 Blood Clots
 Blood Disorder

Do you have any history of cancer? Yes No Type? _____

Symptom Review

Y N
 Fever
 Dizziness
 Nausea/Vomiting
 Chest Pain
 Diarrhea
 Swelling

Y N
 Fatigue
 Muscle Pain
 Bone Pain
 Neck Pain
 Back Pain or Injury
 Numbness

Y N
 Cold Hands/Feet
 Burning
 Tremors
 Difficulty Breathing
 Shortness of Breath
 Painful/Frequent Urination

Please list your past surgeries with the date:

Are you pregnant or breastfeeding? __ Yes __ No

Social History

- Do you currently smoke or chew tobacco? __ Yes __ No If no, have you in the past? __ Yes __ No
How many packs per day? _____
- Do you drink alcohol, beer or wine? __ Yes __ No If no, have you in the past? __ Yes __ No
How many drinks per week? _____
- Do you use street drugs or other substances? __ Yes __ No
- Please List _____

HCPOA

Do you have a Healthcare Power of Attorney? __ Yes __ No

If yes, please provide the following information:

Name: _____

Address: _____

Phone: _____

I certify that the above information is true and correct to the best of my knowledge:

Signature of patient or patient representative: _____

Date: _____

Queen City Foot and Ankle Specialists P.C.

Notice of Privacy Practices for Protected Health Information

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully!

The office/hospital is permitted by federal privacy laws to make uses and disclosures of your health information for purposes of treatment, payment and health care operations. Protected health information is the information we create and obtain in providing our services to you. Such information may include documenting your symptoms, examination, and test results, diagnoses, treatment, and applying for future care or treatment. It also includes billing documents for those services.

Examples of Uses of Your Health Information for Treatment Purposes are:

- A nurse obtains treatment information about you and records it in a health record.
 - During the course of your treatment, the physician determines he/she will need to consult with another specialist in the area or one of your current healthcare providers. He/she will share the information with such specialist and obtain his/her input.
 - Our office may leave appointment reminders via Telephone, Voicemail, and/or Email
 -

Example of Use of Your Health Information for Payment Purposes:

We submit requests for payment to your health insurance company. The health insurance company (or other business associate helping us obtain payment such as workers compensation) requests information from us regarding medical care given. We will provide information to them about you and the care given.

Example of Use of Your Information for Health Care Operations:

We obtain services from our insurers or other business associates such as quality assessment, quality improvement, outcome evaluation, protocol and clinical guideline development, training programs, credentialing, medical review, legal services, and insurance. We will share information about you with such insurers or other business associates as necessary to obtain these services.

Your Health Information Rights

The health and billing records we maintain are the physical property of the office/hospital. The information in it, however, belongs to you. You have a right to:

- Request a restriction on certain uses and disclosures of your health information by delivering the request to our office/hospital -- we are not required to grant the request, but we will comply with any request granted;
- Request a restriction on disclosures of medical information to a health plan for purposes of carrying out payment or health care operations (and is not for purposes of carrying out treatment; and the PHI pertains solely to a health care service for which the provider has been paid out of pocket in full)—we must comply with this request;
- Obtain a paper copy of the current Notice of Privacy Practices for Protected Health Information ("Notice") by making a request at our office/hospital;
- Request that you be allowed to inspect and copy your health record and billing record – you may exercise this right by delivering the request to our office/hospital;
- Appeal a denial of access to your protected health information, except in certain circumstances;
- Request that your health care record be amended to correct incomplete or incorrect information by delivering a request to our office/hospital.

We may deny your request if you ask us to amend information that:

- Was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
- Is not part of the health information kept by or for the office/hospital;
- Is not part of the information that you would be permitted to inspect and copy; or,
- Is accurate and complete.

If your request is denied, you will be informed of the reason for the denial and will have an opportunity to submit a statement of disagreement to be maintained with your records;

- Request that communication of your health information be made by alternative means or at an alternative location by delivering the request in writing to our office;
- Obtain an accounting of disclosures of your health information as required to be maintained by law by delivering a request to our office/hospital. An accounting will not include uses and disclosures of information for treatment, payment, or operations; disclosures or uses made to you or made at your request; uses or disclosures made by authorization signed by you; disclosures made in a facility directory or to family members or friends relevant to that person's involvement in your care; or disclosures to notify family/others responsible for your care of your location, condition, or your death.
- Revoke authorizations that you made previously to use or disclose information by delivering a written revocation to our office, except to the extent that the action has already been taken.

If you want to exercise any of the above rights, please contact [Queen City Foot & Ankle Specialists 11030 S Tryon St Suite 308, Charlotte, NC 28273](#), in person or in writing during regular business hours. The office will inform you of the steps that need to be taken to exercise your rights.

Our Responsibilities

The office is required to:

- Maintain the privacy of your health information as required by law;
- Provide you with a notice as to our duties and privacy practices as to the information we collect and maintain about you;
- Notify you if we cannot accommodate a requested restriction or request; and,
- Accommodate your reasonable requests regarding methods to communicate health information with you.

We reserve the right to amend, change, or eliminate provisions in our privacy practices and access practices and to enact new provisions regarding the protected health information we maintain. If our information practices change, we will amend our Notice. You are entitled to receive a revised copy of the Notice by calling and requesting a copy of our "Notice" or by visiting our office and picking up a copy.

To Request Information or File a Complaint

If you have questions, would like additional information, or want to report a problem regarding the handling of your information, you may contact **Queen City Foot and Ankle Specialists P.C.**

Additionally, if you believe your privacy rights have been violated, you may file a written complaint at our office by delivering the written complaint to **Queen City Foot and Ankle Specialists P.C.** You may also file a complaint by mailing it or e-mailing it to the Secretary of Health and Human Services.

- We cannot, and will not, require you to waive the right to file a complaint with the Secretary of Health and Human Services (HHS) as a condition of receiving treatment from the office.
- We cannot, and will not, retaliate against you for filing a complaint with the Secretary of Health and Human Services.

Other Disclosures and Uses

Communication with Family

- Using our best judgment, we may disclose to a family member, other relative, close personal friend, or any other person you identify, health information relevant to that person's involvement in your care or in payment for such care if you do not object or in an emergency.

Notification

- Unless you object, we may use or disclose your protected health information to notify, or assist in notifying, a family member, personal representative, or other person responsible for your care, about your location, and about your general condition, or your death.

Research

- We may disclose information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your protected health information.

Disaster Relief

- We may use and disclose your protected health information to assist in disaster relief efforts.

Organ Procurement Organizations

- Consistent with applicable law, we may disclose your protected health information to organ procurement organizations or other entities engaged in the procurement, banking, or transplantation of organs for the purpose of tissue donation and transplant.

Food and Drug Administration (FDA)

- We may disclose to the FDA your protected health information relating to adverse events with respect to food, supplements, products and product defects, or post-marketing surveillance information to enable product recalls, repairs, or replacements.

Workers Compensation

- If you are seeking compensation through Workers Compensation, we may disclose your protected health information to the extent necessary to comply with laws relating to Workers Compensation.

Public Health

- As authorized by law, we may disclose your protected health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability; to report reactions to medications or problems with products; to notify people of recalls; to notify a person who may have been exposed to a disease or who is at risk for contracting or spreading a disease or condition.

Abuse & Neglect

- We may disclose your protected health information to public authorities as allowed by law to report abuse or neglect.

Employers

- We may release health information about you to your employer if we provide health care services to you at the request of your employer, and the health care services are provided either to conduct an evaluation relating to medical surveillance of the workplace or to evaluate whether you have a work-related illness or injury. In such circumstances, we will give you written notice of such release of information to your employer. Any other disclosures to your employer will be made only if you execute a specific authorization for the release of that information to your employer.

Correctional Institutions

- If you are an inmate of a correctional institution, we may disclose to the institution or its agents the protected health information necessary for your health and the health and safety of other individuals.

Law Enforcement

- We may disclose your protected health information for law enforcement purposes as required by law, such as when required by a court order, or in cases involving felony prosecution, or to the extent an individual is in the custody of law enforcement.

Health Oversight

- Federal law allows us to release your protected health information to appropriate health oversight agencies or for health oversight activities.

Judicial/Administrative Proceedings

- We may disclose your protected health information in the course of any judicial or administrative proceeding as allowed or required by law, with your authorization, or as directed by a proper court order.

Serious Threat

- To avert a serious threat to health or safety, we may disclose your protected health information consistent with applicable law to prevent or lessen a serious, imminent threat to the health or safety of a person or the public.

For Specialized Governmental Functions

- We may disclose your protected health information for specialized government functions as authorized by law such as to Armed Forces personnel, for national security purposes, or to public assistance program personnel.

Other Uses

- Other uses and disclosures, besides those identified in this Notice, will be made only as otherwise required by law or with your written authorization and you may revoke the authorization as previously provided in this Notice under "Your Health Information Rights."

Website

- If we maintain a website that provides information about our entity, this Notice will be on the website.

Name of Patient: _____

Patient Date of Birth: _____

Acknowledgement of Receipt of Notice of Privacy Practices

I acknowledge that I have received a copy of Provider's Notice of Privacy Practices with the effective date of June 2011

Signature of Patient/Patient Representative

Date

Relationship to Patient

Documentation of Good Faith Efforts To obtain patient's acknowledgment that they received provider's Notice of Privacy Practices

(For use when acknowledgment cannot be obtained from the patient.)

The patient presented to the office/hospital on [insert date] and was provided with a copy of Covered Entity's Notice of Privacy Practices. A good faith effort was made to obtain from the patient a written acknowledgment of his/her receipt of the Notice. However, such acknowledgement was not obtained because:

- Patient refused to sign.
- Patient was unable to sign or initial because:

- The patient had a medical emergency, and an attempt to obtain the acknowledgment will be made at the next available opportunity.
- Other reason (describe below):

Signature of Employee Completing Form: _____

Date Signed: _____