Asheville Podiatry Associates

Doctors Park, Suite 5A
Asheville, NC 28801
828-252-9424

Dr. Douglas Milch **Dr. Debra Wright**

WELCOME TO OUR OFFICE ~ Please complete the following information using a black pen:

Patient Information Date: _____/_____/_____

(Use FULL LEGAL name)

Last Name: ____________________________ First Name: ___________________ Initial: _____ Nickname: ___________________

Date of Birth: ______/______/______ Age: ______ Marital Status: M S W D Sep Sex: M F

Mailing Address: Street ___________________________ Apt/Unit _____ City ________________________ State ____ Zip_______

Phone Numbers: Home (___) __________________ Business (___) _______________________ Cell (___) ____________________

Email: _______________________________________ Social Security Number: _____________________________________

Name of Spouse or Parent/Guardian/Guarantor if patient is a minor: ____

Emergency Contact: Name ____ Relationship ________________________

Address ____ Phone # (___) ________________________

Family Physician/Medical Group: ____ Phone # (___) ________________________

Insurance Information

Primary Insurance: ____

Policy Holder's Name: _______________________________ I.D.# ___________________________Group # __________________

Policy Holder's Date of Birth: _____/_____/_____ Policy Holder's Employer: ____

Secondary Insurance: ____

Policy Holder's Name: _______________________________ I.D.# ___________________________Group # __________________

Policy Holder's Date of Birth: _____/_____/_____ Policy Holder's Employer: ____

Check One - Is this policy: A purchased Medigap ☐ or An employer supplement ☐

Responsible party if other than patient: Name ___________________________________ Relationship ________________________

Address ____ Phone # (___) _______________________

*Payment of Deductible, Percent, or Copay is due at the time of the visit.
*$30 fee is applied if our office is not given at least a 24-hour cancellation notice.

I authorize release of any information concerning my / or my child's healthcare, advice, and treatment provided for the purpose of evaluating and administering claims for insurance benefits. I also hereby authorize payment of insurance benefits not paid by myself, directly to Asheville Podiatry Associates.

Signature: ____ Date: _____/_____/_____

Who may we thank for referring you? Physician Patient Telephone Book Internet Ad Other: _____________________

Name of referring person: ____

Asheville Podiatry Associates, P.A.

Doctors Park, Suite 5A

417 Biltmore Avenue

Asheville, North Carolina 28801

Phone 828-252-9424

Fax 828-251-1301

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ACKNOWLEDGMENT OF RECEIPT

OF

NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read if I so chose) and understand the Notice.

I authorize Asheville Podiatry Associates, P.A. to discuss my medical and payment information with the following person(s): *example: spouse, family member, close associate, etc.*

Name: ____

Name: ____

Name: ____

Patient Name: (please print) ____

Parent of Authorized Representative (if applicable) ___________________________________

Signature: ____ Date: ______ / _____ / _____

Revised 5/2016

Asheville Podiatry Associates, P.A.

Name: ______________________________________ **Date:** ______________

Complaint: ____

How long has this been bothering you? _______Days _______Months _______Years

Please circle the answers to the questions below:

Did the problem start: gradually or suddenly?
Is the problem: worsening, improving or staying the same?
What type of pain are you having? Sharp, dull, aching, throbbing, burning.
Is the pain: constant or intermittent?
Is the problem worse with: weight bearing, non-weight bearing or both?
What previous treatment have you received for this problem?
Medication: (please specify) _____________________________
Different shoes, padding, shoe inserts, rest, surgery
Other treatment: (please specify) _________________________
Did these treatments help? Yes / No

Health History: (Please circle all that apply)

AIDS	Cancer	Heart Problems	Liver Disease	Stroke
Anemia	Circulation Problems	High Blood Pressure	Lung Disease	Thyroid Disease
Arthritis	Diabetes	High Cholesterol	Osteoporosis	Unequal Leg Length
Asthma	Hepatitis	Kidney Disease	Stomach Problems	Other: ____________________

Social History: Alcohol use: Yes / No Circle all that apply: Wine, Beer, Liquor
How often? Daily 1-2 week 3-5 week 1-2 month 3-5 month Used in the Past

Tobacco use: Yes / No Circle all that apply: Cigars, Cigarettes, Electronic Cigarettes, Oral, Pipe, Snuff
Amount per day? ________________ Used in the Past ☐

Family History: Any relatives with similar foot problems? Yes / No What relation? ____________________________

Please list <u>all</u> surgeries: (tonsillectomy, appendectomy, etc.)

____
____
____
____

What Pharmacy and Location do you use?

____

I give my consent to Asheville Podiatry Associates to contact my pharmacy in order to obtain my current list of medications, and to contact my physician's office to obtain my past medical history.

Signature: ____

Please list <u>all</u> medications including prescription and over the counter vitamins, minerals and supplements:
Name of Medicine: **Dosage:**

____
____
____
____
____

~ OVER~

Are you allergic to any medications? Yes / No *If yes, please explain*: ____

____

____

Are you allergic to latex? Yes _______ No _______

Review of Systems - Please circle conditions that apply:

Constitutional	**Respiratory**	**Musculoskeletal**	**Cardiovascular**	**Endocrine**
Fever	Cough	Foot/Leg injuries	Chest pain	High blood sugar
Weakness	Wheezing	Joint pain/stiffness	Palpitations	Low blood sugar
Fatigue	Shortness of breath	Back pain/neck pain	Poor circulation	Frequent urination
Weight gain	Sleep apnea	Weakness	Fainting	Excessive thirst
Weight loss	Snoring	Muscle cramps	Varicose veins	Cold/Heat intolerance
			Leg swelling	
Skin	**Neurological**	**Immune System**	**Gastrointestinal**	**Blood/Lymph**
Dryness	Abnormal balance	Frequent infections	Nausea	Bleeding tendency
Itching	Numbness	Chemotherapy	Vomiting	Bruising tendency
Skin Lesions	Headache	High Dose Steroids	Diarrhea	Other: ____________
Scars	Tingling	Transplant	Heart burn	
Rash	Restless leg	Other: ____________	Loss of Appetite	
Other: ____________	Other:____________		Other: ____________	

Preferred Language: ______________________________ **Height:** ________________ **Weight:** ____________

Race: __________________________ **Ethnicity:** ______________________________ **Shoe Size:** __________

Signature: _________________________________ **Printed Name:** _________________________ **Date:** ________

FOR OFFICE USE ONLY ____

B/P _____________/_____________ **Temp:** ____________

Revised September 2015

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Doctors Park, Suite 5 A
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I understand and agree that (regardless of my insurance status) I am ultimately responsible for the balance on my account for any professional services rendered. I will notify you of any changes in my health status or the information pertaining to my insurance.

I hereby assign all medical/surgical benefits to which I am entitled including Medicare and other government sponsored programs, private insurance and any other health plans to Asheville Podiatry Associates, P.A. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure payment of said benefits.

I request that payment of authorized Medigap benefits be made on my behalf to Asheville Podiatry Associates, P.A. for any services furnished to e by that physician/supplier.

I have read all the information above and understand same.

X ______________________ X ______________________
Patient Date

______________________ ______________________
Witness Date

Revised 9/2015

Authorization for Release of Information – Compound Release

Name of Patient ____ Date of Birth _______________

Asheville Podiatry Associates, P.A. is authorized to release protected health information about the above named patient in the following manner and to identified persons:

Entity to Receive Information. Check each person/entity that you approve to receive Information.	**Description of information to be released.** Check each that can be given to person/entity on the left in the same section.
☐ Voice Mail	☐ Results of lab tests/x-rays Other: _______________________________
☐ Spouse (provide name and phone number) _______________________________________	☐ Financial ☐ Medical
☐ Parent (provide name and phone number) _______________________________________	☐ Financial ☐ Medical
☐ Email communications – Provide email address* _______________________________________ *In order for email communication to occur, please accept the disclosure below.	☐ Financial ☐ Medical ☐ Breach notification

☐ For email communication I understand that if email is not sent in an encrypted manner there is a risk it could be accessed inappropriately. I still elect to receive email.

☐ Communication about treatment alternatives even if this office is being compensated for making the communication.

Patient Rights:

- I have the right to revoke this authorization at any time.
- I may inspect or copy the protected health information to be disclosed as described in this document.
- Revocation is not effective in cases where the information has already been disclosed but will be effective going forward.
- Information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.
- I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing.

The information is released at the patient's request and this authorization will remain in effect until revoked by the patient.

____ Date: ____________________

Signature of Patient or Personal Representative

*Description of Personal Representative's Authority (attach necessary documentation)

Revised September 2015

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Directions to our office:

We are located in Doctors Park at 417 Biltmore Avenue, Suite 5A. Doctors Park is an office complex consisting of a group of brick buildings directly across the street from St. Joseph's Mission Hospital Campus. Doctors Park is located between Choctaw Avenue and Brooklet Street. Our office is in Building Five which is the building closest to Choctaw Street. As you enter Doctors Park, Building Five is the furthest building on the right. We are located at the far end of Building Five in Suite 5A, which is next to the stop sign. If you get lost, even with these great directions, please call and we will talk you in. (828) 252-9424.

Mission Hospitals St. Josephs' Campus
Biltmore Avenue
Doctors Park
Doctors Park Florist
Building 1
445 Biltmore
Victoria Rd.
Choctaw St.
Building 5
Buildin
Building 2
Brooklet St.
Asheville Podiatry
Doctors Park
Suite 5A
Carport
Building 3