Southeast New Mexico Podiatry Associates

Medical and Surgical Treatment of the Foot and Ankle
Dr. Lyle Folsom Dr. Joshua Cady. Dr. Derik Brown
1016 W. Pierce Street. Carlsbad, NM 88220
5419 N. Lovington Hwy. STE 9 Hobbs, NM 88240
Carlsbad Phone: 575-885-3445 Hobbs Phone: 575-964-8770 Fax: 575-887-0163

Name: Last ________________________ First ________________________ MI: _____

Date of Birth: _____________________ Social Security Number: ________________________

Height: _______Weight: _______ Sex: _______ Shoe Size & Width: ______________

Mailing Address: ____

City/State: _____________________ Zip:_______

Billing Address: ____

City/State: _____________________ Zip:_______

Home Phone: ____________________ Cell: ____________________Work: _______________

Marital Status: __________________________ Living Arrangements: ____________________

Employer: _________________________________ Occupation: ________________________

Emergency Contact: __________________________ Phone Number: ____________________

Email Address: ____

Race: _____________________________ Ethnicity: _________________________________

Preferred Language: ________________________________

Primary Care Doctor: ______________________ Endocrinologist: _____________________

Cardiologist: _____________________ Other Specialist:_____________________________

Preferred Pharmacy and location: ____

Who can we thank for referring you? ____

PATIENT SIGNATURE_____________________________________ DATE: ______________

All Paperwork MUST be completed and signed BEFORE you can see the doctor.

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Insurance Guarantor Information:

Responsible Party - If the patient is a minor (under the age of 18), the parent or guardian will be listed as the guarantor:

Last Name: _______________________________ First Name: _____________________

Date of Birth: _____________________ Social Security Number: _______________________

Relationship to Patient: ________________________

Address/City/State/Zip: ____

Primary Medical Insurance	Secondary Medical Insurance
Ins Co. Name	Ins Co. Name
Policy Holder Name	Policy Holder Name
Policy Holder DOB	Policy Holder DOB
Policy Holder SS#	Policy Holder SS#
Relationship to Patient	Relationship to Patient

Authorization to Release Information: I/We hereby authorize Southeast NM Podiatry Associates to release any medical or incidental information that may be necessary for medical benefit or in processing applications for financial benefit. This includes but is not limited to my insurance company, rehabilitation services, social security administration and worker's compensation.

Consent for Treatment: I/We hereby authorize Southeast NM Podiatry Associates to administer diagnostic and medical procedures as may be necessary for proper health care.

Office Policy on Payment: I understand that I am responsible for payment of all charges. As a courtesy, my insurance company. I authorize insurance benefits to be paid directly to Southeast NM Podiatry Associates.

I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS ALL CLAIMS:

PATIENT SIGNATURE_____________________________________ **DATE:** ______________

I AUTHORIZE THE RELEASE OF PAYMENT FOR MEDICAL BENEFITS TO MY PHYSICIAN

PATIENT SIGNATURE_____________________________________ **DATE:** ______________

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Reason for Visit:

What is the reason for your visit? ____
____
____
When did this problem start? ____
____
Did this problem develop slowly or suddenly? (please circle)
What have you done to help with this problem? _________________________________
____
____
What type of pain are you having? Sharp Dull Burning Aching Cramping Throbbing
Other (Describe) ____
On a scale of 1-10, how would you rate your pain level if 1 is the least painful and 10 is the most painful? 1 2 3 4 5 6 7 8 9 10

Patient Allergy Assessment:

List any allergies to drugs, food, vegetation or adhesives:
____
____

Have you ever had a reaction to any of the following anesthetics or medications?

Local Anesthetics	No	Yes
General Anesthetics	No	Yes
Antibiotics	No	Yes
Narcotics	No	Yes
Barbiturates	No	Yes

Do you have a history of taking any of the following medications?

Steroids (Cortizone)	No	Yes
Anticoagulants (Aspirin, Coumadin, Heparin)	No	Yes
Antihypertensives	No	Yes
Tranquilizers	No	Yes

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Social History:

Use of Alcohol: Number of Beverages:
Never: ______________ Week: ___________ Month: _____________ Year: ___________
Use of Tobacco: Smoke/Vape
Never: _________________ Current (packs/day):______________ Previously: _______________
Use of Drugs:
Never: _________________ Type/Frequency: ____
Occupation: _____________________________ Shoe Requirements: ________________________

Surgical History: Please list **ALL** surgeries:

Surgery Performed _________________________________ Date: _________ Physician: ____________
Surgery Performed _________________________________ Date: _________ Physician: ____________
Surgery Performed _________________________________ Date: _________ Physician: ____________
Surgery Performed _________________________________ Date: _________ Physician: ____________
Surgery Performed _________________________________ Date: _________ Physician: ____________
Surgery Performed _________________________________ Date: _________ Physician: ____________

Current Medical History: Primary Care Doctor: ____________________________

List any other medical providers you see on a regular basis:______________________________
____

Tuberculosis	Yes	No	Bleeding Problems	Yes	No
High Fever	Yes	No	Heart Attack	Yes	No
Skin Ulcer	Yes	No	Heart Failure	Yes	No
Shock	Yes	No	Cancer	Yes	No
Coma	Yes	No	Liver Problems	Yes	No
Arthritis	Yes	No	Kidney Problems	Yes	No
High Blood Pressure	Yes	No	Gastric Ulcer	Yes	No
Low Blood Pressure	Yes	No	Glaucoma	Yes	No
Venous Problems	Yes	No	Arterial Problems	Yes	No
Diabetes: **Type I or Type II** (Please Circle)	Yes	No	Stroke	Yes	No

List any medical problem not listed above: ____
____

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Review of Systems (ROS)

Do you currently have any of the following?:

General:
Changes in Appetite: ☐ Yes ☐ No
Chills: ☐ Yes ☐ No
Fever: ☐ Yes ☐ No
Weight Changes: ☐ Yes ☐ No

Respiratory:
Problems Breathing: ☐ Yes ☐ No
Shortness of Breath: ☐ Yes ☐ No
Asthma: ☐ Yes ☐ No
Sinus: ☐ Yes ☐ No

Gastrointestinal:
Change in Bowel Habits: ☐ Yes ☐ No
Constipation: ☐ Yes ☐ No
Diarrhea: ☐ Yes ☐ No
Gallstones: ☐ Yes ☐ No
GERD: ☐ Yes ☐ No
Heartburn: ☐ Yes ☐ No
Nausea: ☐ Yes ☐ No
Jaundice: ☐ Yes ☐ No
Fatty Liver: ☐ Yes ☐ No
Hepatitis: ☐ Yes ☐ No

Musculoskeletal
Arthritis: ☐ Yes ☐ No
Crepitations: ☐ Yes ☐ No
Deformity ______________________________
Limitation of Motion: ☐ Yes ☐ No

Cardiac:
High Blood Pressure: ☐ Yes ☐ No
Low Blood Pressure: ☐ Yes ☐ No
Irregular Heartbeat: ☐ Yes ☐ No
Murmur: ☐ Yes ☐ No

Neurological
Paresis/Paralysis: ☐ Yes ☐ No
Stroke: ☐ Yes ☐ No
Dizziness: ☐ Yes ☐ No
Tremors: ☐ Yes ☐ No
Numbness: ☐ Yes ☐ No
Nervous Disorder: ☐ Yes ☐ No
Convulsions: ☐ Yes ☐ No

Endocrine/Metabolic
Diabetes (Type I or Type II): ________________
Most Recent A1C: ________________
Year Diagnosed: ________________
Excessive Sweating: ☐ Yes ☐ No
Foot Ulcers: ☐ Yes ☐ No
Heat Intolerance: ☐ Yes ☐ No
Thyroid Problems: ☐ Yes ☐ No
Gout: ☐ Yes ☐ No
Hormone Problems: ☐ Yes ☐ No

Hematologic/Lymphatic
Anemia: ☐ Yes ☐ No
Bleeding: ☐ Yes ☐

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Muscle Cramps: ☐ Yes ☐ No
Joint Swelling: ☐ Yes ☐ No
Joint Stiffness: ☐ Yes ☐ No
Foot/Ankle Injury: ☐ Yes ☐ No

Peripheral Vascular
Cramps: ☐ Yes ☐ No
Intermittent Claudication: ☐ Yes ☐ No
Thrombophlebitis: ☐ Yes ☐ No
Varicose Veins: ☐ Yes ☐ No
Rest Pain: ☐ Yes ☐ No

Blood Transfusion: ☐ Yes ☐ No
Easy Bruising: ☐ Yes ☐ No
Lymphadenopathy: ☐ Yes ☐ No
Skin Pallor: ☐ Yes ☐ No

Genitourinary
Kidney problems: ☐ Yes ☐ No
Frequent Urination: ☐ Yes ☐ No
Bladder Problems: ☐ Yes ☐ No
Burning/Painful Urination: ☐ Yes ☐ No
Blood in Urine: ☐ Yes ☐ No

Last Menstrual Cycle ____________________
Number of Pregnancies ____________________
Number of Miscarriages ____________________

PATIENT SIGNATURE____________________________________ **DATE:** ______________

Family Medical History:

- **Foot Problems:** Yes or No
  - Amputation: ____________ Relationship to Patient: ________________________
  - Athlete's Foot: _____________ Relationship to Patient: ________________________
  - Bunions: ________________ Relationship to Patient: ________________________
  - Hammertoes: ____________ Relationship to Patient: ________________________
  - Diabetic Foot Ulcer: __________ Relationship to Patient: ______________________
  - Plantar Fasciitis: ____________ Relationship to Patient: ________________________
  - Warts: _____________ Relationship to Patient: ________________________
- **Diabetes:** Circle: Type I or Type II
  Relationship to Patient: _________________________
- **High Blood Pressure/Hypertension**: Yes or No
  Relationship to Patient: _________________________
- **Cardiac Disease** Yes or No
  Relationship to Patient: _________________________
- **Arthritis** Yes or No
  Relationship to Patient: _________________________
  - DJD/Osteoarthritis
  - Gout
  - Rheumatoid
- **Gout** Yes or No
  Relationship to Patient: _________________________
- **Neurologic Disease** Yes or No
  - Seizure Relationship to Patient: ______________________

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  - Charcot Marie Tooth Syndrome Relationship to Patient: ___________________________
  - Neuropathy Relationship to Patient: ___________________________
- **Cancer:** Yes or No Type: ____
  Relationship to Patient: _____________________________
- **Bleeding Disorder** Yes or No
  Relationship to Patient: _____________________________
- **Stroke** Yes or No
  Relationship to Patient: _____________________________
- **Other** ____
  Relationship to Patient: ____________________

PATIENT SIGNATURE____ **DATE:** ________________
Date: ____________________________
Patient Name: ____ DOB: ____________________
Allergies or Drug Reactions: ____
____

Current Medications:

Name of Medication	Dosage/Frequency	Date Prescribed	Dr. Who Prescribed	Pharmacy

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PATIENT SIGNATURE________________________________ **DATE:** ____________

Have you had any recent tests: (X-Rays, Blood Tests, MRI, CT Scan, Ect…): ____________________

Do you have a copy of the report with you today: ____________________

Do you have an X-Ray or CD with you today? ____________________

When was it performed? ____________________

Who was the doctor that ordered the test? ____________________

Please sign below to authorize our office to receive your medical information:

I, ________________________________, give permission for Southeast New Mexico Podiatry to obtain my medical information.

Signature: ________________________ **Date:** ____________

Print Name: ________________________ **Date of Birth:** ____________

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Health Insurance Portability and Accountability Act (HIPAA)

I understand that under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) 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 physical certifications

I have been informed by you and your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such *Notice of Privacy Practices* prior to signing this consent. I understand that this organization at any time at the address above may 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 and disclosed to carry out treatment, payment or healthcare operations. I also understand you are not required to agree to my restricted restrictions, but if you agree then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

I authorize the following persons to obtain information regarding my health information (including but not limited to: blood tests, test results, prognosis reports, ect…)

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This may include family members, close friends, other relatives, employers, or any other person you choose to list.

__________________________ __________________________

__________________________ __________________________

__________________________ __________________________

__________________________ __________________________

__________________________ __________________________

Patient Name: ____________________ Relationship to Patient: __________________
Signature: ______________________________ Date: ______________

Patient Financial & Payment Policy

This financial payment policy is an agreement between Southeast New Mexico Podiatry and you, the patient, or responsible party. By signing the patient registration form, you are acknowledging that you understand and agree to our financial payment policy.

Patient Responsibility:

- **You must provide us with a current insurance card and billing information**. Your insurance policy is a contract between you and your insurance company. It is your responsibility to know your insurance benefits and pay any remaining portion due after insurance processes your claim. It is also your responsibility to ensure changes to your insurance are updated with our office. Failure to update your insurance information may result in charges being transferred to the patient as an out of pocket cost.
- **Copays and coinsurance costs** are due at the time of service.
- **NSF Fees:** A $20.00 returned check fee will be charged for checks returned due to insufficient funds.
- **Workers' Compensation Plans:** You are responsible for ensuring that your employer submits any required documentation. If your insurance company

denies the claim because your employer failed to file documentation, the bill will become your responsibility.

I understand that I am financially responsible for all charges regardless of third-party involvement. I agree to pay any deductible, co-insurance, copay or any service(s) deemed a “non-covered benefit” by my insurance company. I understand that failure to pay outstanding balances or set up a payment plan with the Office Manager or Billing Manager will result in the submission of my account to an outside collection agency. If the debt remains after transfer to our outside collection agency, the debt may be reported to the credit bureaus and your credit rating may be affected. In addition, failure to pay delinquent account balances may result in termination of care from Southeast New Mexico Podiatry Associates.

PATIENT SIGNATURE___________________________________ DATE: _____________