Carolina Foot & Ankle

Mark A. Quist, D.P.M.
Physician and Surgeon of the Foot & Ankle
❒ 16419 Northcross Dr, Suite A, Huntersville, NC 28078
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❒ 206 Joe Knox Avenue, Suite D, Mooresville, NC 28117
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Physician and Surgeon of the Foot & Ankle
❒ 10310 Couloak Drive, Charlotte, NC 28216
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We would like to take this opportunity to welcome you to our office and thank you for choosing us to help you with your foot problem.

Please fill out all pages as accurately as possible. Thank you.

Name: _____ Date of Birth: _____ Age: _____
First MI Last

Street: _____ Home Phone: _____

City/State: _____ Cell Phone: _____

Zip Code: _____ Email Address: _____

Social Security #: _____ Ethnicity/Race: _____

Male: ❑ Female: ❑ Marital Status: ❑ Married ❑ Single ❑ Divorced ❑ Widowed

If patient is a minor, name of responsible party: _____

Responsible Party Address: _____

Whom may we call in case of emergency: Name: _____ Phone: _____

Name of your primary care physician: _____ Last Visit: _____

Whom may we thank for referring you to this office? _____

❑ Friend: _____ ❑ Dr: _____

❑ Yellow Pages ❑ Sign ❑ Other: _____

Do you have Medical Insurance? ❑ Yes ❑ No

How are you paying for your visit today? ❑ Cash ❑ Credit Card

PRIMARY INSURANCE:

Name of Insurance Company: _____

Person Insured as Primary Policy Holder: _____ **Primary Policy Holder's DOB:** _____

Employer: _____ Employer Phone #: _____

Primary Policy Holder's Social Security Number: _____

SECONDARY INSURANCE

Name of Insurance Company: _____

Person Insured as Primary Policy Holder: _____ **Primary Policy Holder's DOB:** _____

MEDICAL INFORMATION

This Information Is Important For Our Records and Your Health.

MEDICAL HISTORY:

Check ☑ any of the following you have, or have had a problem with:

- ❑ Anemia
- ❑ Arthritis
- ❑ Asthma
  - ❑ COPD
- ❑ Bladder
- ❑ Cancer
- ❑ Circulation/Blood Clots
- ❑ Frequent Infections
- ❑ Gout
- ❑ Heart
  - ❑ CHF
- ❑ Hepatitis or HIV
- ❑ Hypertension
- ❑ Kidneys Problems
- ❑ Neurological Disorder
- ❑ Psychiatric Disorder
- ❑ Stomach Ulcers
- ❑ Stroke
- ❑ Thyroid
  - ❑ Hyper ❑ Hypo
- ❑ Tuberculosis
- ❑ Unexplained Fever/Weight Loss

Do you have Diabetes? ❑ Yes ❑ No If yes, do you take insulin? ❑ Yes ❑ No Number of years?_____

Average sugar? A_1C _____

Are you under a physician's care? ❑ Yes ❑ No Physician Name:

List all conditions you're being treated for: _____

_____

May we contact your phyisican about your health? ❑ Yes ❑ No

SURGICAL HISTORY:

Please list any past surgeries: _____

Do you have artificial joints? Hip ❑ Yes ❑ No

Knee ❑ Yes ❑ No Other _____

Do you have Heart Valve Implant? ❑ Yes ❑ No

FAMILY HISTORY:

Mother	❑ Living	❑ Deceased	Cause of Death: _____
Father	❑ Living	❑ Deceased	Cause of Death: _____
Brother	❑ Living	❑ Deceased	Cause of Death: _____
Sister	❑ Living	❑ Deceased	Cause of Death: _____

Is there a family (blood relative) history of:

- ❑ Arthritis
- ❑ Circulation problems in legs or feet? _____
- ❑ Bleeding Disorder
- ❑ Flatfeet
- ❑ Heart Disease
- ❑ Stroke
- ❑ Bunions
- ❑ Hammertoes
- ❑ Neurological Disorder

SOCIAL HISTORY:

Do you smoke? ❑ Yes - # packs per day _____ ❑ No

Previously smoked? ❑ Yes - # of years _____ ❑ No

Do you drink alcohol or beer? ❑ Yes ❑ No

❑ Light usage 1-2 per week ❑ Moderate 1-2 per day ❑ Heavily more than 2 daily

Employment: ❑ Sit at Job ❑ Stand at Job ❑ Stand and Walk at Job ❑ Retired

GENERAL HEALTH INFORMATION

Preferred Pharmacy (Names/City) : _____

What medications do you take regularly? _____

_____

_____

_____

Describe your foot problem:

_____

_____

_____

Was it caused by injury or work related? ❑ Yes ❑ No

_____

How long has it been bothering you? _____ Days _____ Weeks _____ Months _____ Years

And does it bother you everyday? ❑ Yes ❑ No

Any past problems of your feet and ankles? ❑ Yes ❑ No

On a scale of 1-10 how bad is your foot/ankle pain?*(please circle)* 1 2 3 4 5 6 7 8 9 10

Any past surgical procedures on your feet or ankles?

Is the pain ❑ intermittent ❑ constant ❑ getting worse ❑ comes and goes? *(please check)*

Does anything help?

Have you taken any prescriptions?

Shoe size _____ Current Weight _____ Height _____

Are you allergic or sensitive to:

Antibiotic/Medicines (Penicillin, Sulfa Drugs, etc.?) _____

Tape? _____ Betadine (Iodine)? _____ Other? _____

Have you had problems taking aspirin or ibuprofen (Advil, Motrin)? ❑ Yes ❑ No

Any problems with local anesthetics (Novocaine, Lidocaine)? ❑ Yes ❑ No

Signature: Date:

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.

_____ _____

Patient Name (please print) Date

_____

Parent or Authorized Representative (if applicable)

_____

Signature

I hereby give my permission to Carolina Foot & Ankle, to administer treatment; and to perform such minor operative procedures as may be deemed necessary in the diagnosis and/or treatment of my foot condition.

LIFETIME AUTHORIZATION AND ASSIGNMENT OF BENEFITS

I authorize the release of any medical information necessary to process this claim. I permit a copy authorization to be used in place of the original. I consent to the treatment as necessary or desirable to the care of the patient named above, included but not restricted to whatever drugs, medicines, and conduct of laboratory, x-rays, or other studies that may be used by the attending physician, or said physician's nurse or qualified designate. I also acknowledge responsibility for the payment of such services unless other arrangements are made in advance with the finance department.

Date: _____ Patient Signature: _____

Guardian Signature: _____

NOTICE OF PRIVACY PRACTICES

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 Health Insurance Portability & Accountability Act of 1996 (HIPAA) requires all health care records and other individually identifiable health information used or disclosed to us in any form, whether electronically, on paper, or orally, to be kept confidential. This federal law gives you, the patient, significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information. As required by law, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

Without specific written authorization, we are permitted to use and disclose your health care records for the purposes of treatment, payment and health care operations.

- **Treatment** means providing, coordinating, or managing health care and related services by one or more health care providers. For example, we may need to share information with other health care providers or specialists involved in the continuation of your care.
- **Payment** means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. For example, we may disclose treatment information when billing a dental plan for your dental services.
- **Health Care Operations** include the business aspects of running our practice. For example, patient information may be used for training purposes, or quality assessment.

Unless you request otherwise, we may use or disclose health information to a family member, friend, personal representative, or other individual to the extent necessary to help with your health care or with payment for your health care. In the event of an emergency or your incapacity, we will use our professional judgment in disclosing only the protected health information necessary to facilitate needed care. In addition, we may use your confidential information to remind you of appointments by sending reminder postcards and/or leaving messages at home and/or work. Your protected health information may also be used by our office to recommend treatment alternatives or to provide you with information about health-related benefits and services that may be of interest to you. In addition, we may disclose your health information for public health oversight activities, judicial or administrative proceedings, in response to a subpoena or court order, to military authorities of Armed Forces personnel, to federal officials for lawful intelligence, counterintelligence, and other national security activities, to correctional institutions or law enforcement officials, and/or to report suspected abuse, neglect, or domestic violence. Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have certain rights in regards to your protected health information, which you may exercise by presenting a written request to our Privacy Officer at the practice address listed below:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to request to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to access, inspect, and copy your protected health information, with limited exceptions. A reasonable fee may be assessed.
- The right to request an amendment to your protected health information. We may deny your request in certain situations.
- The right to receive an accounting of disclosures of protected health information made outside of treatment, payment, or health care operations...or based on your previous authorization.
- The right to obtain a paper copy of this notice from us upon request, even if you have agreed to receive the notice electronically.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

This notice is effective as of April 14, 2003, and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. Revisions to our Notice of Privacy Practices will be posted on the effective date and you may request a written copy of the Revised Notice from this office.

You have the right to file a formal, written complaint with us at the address below, or with the Department of Health & Human Services, Office of Civil Rights, in the event you feel your privacy rights have been violated. We will not retaliate against you for filing a complaint.

For more information about our Privacy Practices, please contact:

Privacy Officer	Dr. Mark Quist
Office Name	Carolina Foot & Ankle of Huntersville
Address	16511 Northcross Drive, Suite E
City, State, Zip	Huntersville, NC 28078
Phone	704-987-9585

For more information about HIPAA or to file a complaint:

The U.S. Department of Health & Human Services
Office of Civil Rights
200 Independence Avenue, S.W.
Washington, D.C. 20201
877-696-6775 (toll-free)