MEDICAL HISTORY (PLEASE PRINT)

Patient's name: ______________________________________ Social security number: ____________________________ Birthday: ___________

CHIEF COMPLAINT TODAY: ____

Location of problem:________________________ Duration of problem:___________________ Pain level:________________________

Describe nature of pain: **Sharp—Dull—Aching—Burning—Tingling—Itching—Radiating--** Injury associated with problem? Y or N

Have you been treated by another physician: Y or N Is problem work related? Y or N Shoe Size_____________

ALLERGIES: include type of reaction—(anaphylactic, rash, hives, etc.)	**FAMILY MEDICAL HISTORY (IF YES, PLEASE EXPLAIN)**
1.	Tuberculosis? Y N
2.	Cancer? Y N
3.	High Blood Pressure? Y N
4.	Heart problems? Y N
5.	Diabetes? Y N
MEDICATIONS: **include dosages and times per day taken**	Birth abnormalities Y N
1.	Arthritis? Y N
2.	Stroke? Y N
3.	Foot problems? Y N
4.	Other family medical problems:____ ____
5.	
6.	**REVIEW OF SYSTEMS (EXPLAIN ALL CURRENT PROBLEMS)**
7.	**Are you having current problems with the following areas?**
8.	Head? Yes No Explain
9.	Eyes? Yes No Explain
PAST MEDICAL HISTORY (circle all that apply)	Ears? Yes No Explain
GOOD GENERAL HEALTH YES NO	Nose? Yes No Explain
HEART PROBLEMS YES NO	Mouth? Yes No Explain
CHEST PAIN/ANGINA YES NO	Throat? Yes No Explain
CHRONIC COUGHS YES NO	Heart? Yes No Explain:
BREATHING PROBLEM YES NO	Breathing? Yes No Explain:
ABDOMINAL PROBLEM YES NO	Stomach? Yes No Explain:
CONVULSIONS/SEIZURES YES NO	Intestinal? Yes No Explain:
DIABETES YES NO	Urinary? Yes No Explain:
DEPRESSION YES NO	Genitalia? Yes No Explain:
THYROID PROBLEM YES NO	Skin? Yes No Explain:
ANEMIA YES NO	Muscles? Yes No Explain:
CANCER YES NO	Bones? Yes No Explain:
GLANDULAR/HOREMONE PROB. YES NO	Nerves? Yes No Explain:
ARTHRITIS YES NO	Blood? Yes No Explain:
ALCOHOLISM YES NO	Depression? Yes No Explain:
PLEASE EXPLAIN ALL "YES" ANSWERS	Psychological? Yes No Explain:
1.	**CHILDHOOD ILLNESSES**
2.	Measles Yes No
3.	Mumps Yes No
4.	Chickenpox Yes No
5.	Other childhood illnesses?
SOCIAL HISTORY:	**SURGICAL HISTORY/HOSPITALIZATIONS(list year)**
Marital status: Single---Married---Separated----Divorced---Widowed	
Occupation:	
Alcohol use: (circle) never---rare---moderate---daily;	
Tobacco Use: never—previous---current use	
When did you stop smoking?____________ Amount?___________	
Recreational/illegal drug use?	**Do you wear orthotics? Yes No**
Do you have a Living Will ? YES NO	

PATIENT'S SIGNATURE: ____ DATE: _______________________

PHYSICIAN'S SIGNATURE: _____________________________

Patient Information Sheet **(PLEASE PRINT)**
Ocean Pines Foot and Ankle Center, P.A.
Eric Jamrok, D.P.M.

Today's Date________________

( )
Last Name First Name M.I. Home Phone #

Street Address/ P.O. Box Apt. # City State Zip

Sex M F Marital Status M S W
Social Security # Date of Birth Age

Your Primary Physician's Name and Number Referring Physician's Name Referring Friends Name

( )
Financially Responsible Person Address if Different from Patient Phone #

( )
Your Employer's Name Address City State Work #

( )
Spouse's Name Person, Other than Spouse, to Contact in Case of Emergency Relationship Contact #

How did you hear about our Practice? Yellow Pages Other Patient Friend Ins. Co. Dr.'s Referral Other

Insurance Coverage

Name of Policy Holder Relationship Policy Holder's Birth date Employer's Phone # of policy holder

Secondary Ins. Co. Name of policyholder Relationship Policy Holder's D.O.B. Employer's Phone # of policy holder

Medicare Lifetime Signature On File

I requests that payment of authorized Medicare benefits be made either to me or on my behalf to Eric Jamrok, D.P.M. for any services furnished me by the physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and agents any information needed to determine these benefits payable for related services.

Signed Date

Private Insurance Authorization for Assignment of Benefits and Information Release

I, the undersigned, authorized payment of medical benefits to Ocean Pines Foot and Ankle Center, P. A. For any services furnished to me by Eric Jamrok D.P.M. I understand I am financially responsible for any amount not covered by the contract. I also authorize you to release to my insurance company information concerning health care, advice, treatment or supplies provided to me. This information will be used for the purpose of evaluating and administering claims of benefits. I also authorize the release of medical records to my Primary Care Physician. I permit a copy of this authorization to be used in place of the original.

Signed Date

Patient Consent Form
Notice Of Privacy Practices

Eric Jamrok, D.P.M.
Ocean City Foot and Ankle Center, P.A.

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPPA), 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 physician certifications.

I have been informed by you of 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 has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address below to 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 or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do 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.

Signature: ____

Print Name: ____

Relationship to Patient: ____

Date: ____

FINANCIAL POLICY STATEMENT

In order to reduce confusion and misunderstanding between our patients and the practice, we have adopted the following financial policy. If you have any questions about the policy, please discuss them with our office staff.

We are dedicated to providing the best possible care and service to you and regard your complete understanding of your financial responsibilities as an essential element of your care and treatment.

1) Your insurance policy is a contract between you and your insurance company, the doctor is not involved.

2) We have made prior arrangements with many health plans to accept an assignment of benefits. We will bill those plans for whom we have an arrangement and will only require you to pay the authorized co-payment, coinsurance, or deductible at the time of service.

3) If you have insurance coverage with a plan that we do not have a prior agreement, we may prepare and file the insurance claim as a courtesy. However, if your insurance company does not pay the practice within a reasonable length of time, we will have to look to you for payment.

4) Unless other arrangements have been made in advance by either you or your health coverage carrier, **payment in full** for the office services including x-rays **is due at the time of service**. For your convenience we will accept Visa, MasterCard or Discover.

5) All health plans are not the same and do not cover the same services. In the event your health plan determines a service to be "not covered" or "not medical necessary", **you will be responsible for the complete charge**. Payment is due at the time of service or upon receipt of a statement from our office.

6) A Liability Action against someone else is not a reason to delay payment of your bill. Payment of the bill is the responsibility of the individual who has received the treatment, not the individual who is being sued. For this reason, as well as the fact that lawsuits may go on for a protracted period of time, we feel that our bill should be paid promptly. Once this is done we will, of course, fulfill our responsibilities in providing your attorneys with necessary medical information for your legitimate purposes.

7) The patient or legal guardian is responsible for all fees, including collection fees and/or attorney fees, court costs and interest (1% per month) that may accrue on any unpaid balance that is 60 days past due, regardless of insurance coverage.

8) For all services rendered to minor patients, we look to the parent and/or legal guardian who signed the authorization for treatment, regardless of any legal binding agreement in the case of custody arrangements, for payment.

9) <u>ANY MISSED APPOINTMENTS WITHOUT A 24-HOUR NOTICE WILL BE CHARGED A $50.00 FEE.</u>

I have read and understand the financial policy of the practice and I agree to be bound by its terms. I also understand and agree that such terms may be amended from time-to-time by the practice.

______________________________ ____________________

(Signature of patient/legal guardian) (Date)

____

(Please Print Patient's Name)