Brandywine Podiatry
Center of Excellence
www.brandywinepodiatry.com

Patient Health History

Name: **Date of Birth: / /**

Address: _____ Age: _____

City: _____ State: _____ Zip: _____ Sex: Male / Female

Phone #: (Home): _____ (Cell): _____ (Work): _____

Personal Email: _____ Social Security #: _____

Race: _____ Ethnicity: Hispanic/Latino Non-Hispanic/Latino Other

Primary Care Physician and #: _____

Date you last saw your Primary Care Physician: _____

Endocrinologist or Cardiologist and #_____

Employer: _____ Occupation: _____

Insurance subscriber's name and DOB:_____

Emergency Contact: _____ Emergency Contact #: _____

Shoe Size: _____ Are you pregnant?: _____

How did you hear about Brandywine Podiatry?: _____

Reason for visit: _____

Date of Injury or when problem occurred? _____

Allergies: ☐ No Known Allergies ☐ YES If so, please list all Drug, Food, and Environmental Allergies.

_____

Medications : No Prescribed Medications

Medication Name	Dosage	Medication	Dosage

Preferred Pharmacy:

Name of Pharmacy:_____

Pharmacy Location (*Street, City, State*): _____

Pharmacy Phone Number (if known):_____

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Personal Medical History: ☐ No Known Problems; OR please check all that apply

☐ Anemia	☐ Cancer	☐ GI Problems	☐ HIV/AIDS	☐ Neurological Disorder
☐ Anxiety/Depression	☐ COPD	☐ Gout	☐ Hypertension	☐ Poor Circulation
☐ Arthritis	☐ Diabetes	☐ Heart Disease	☐ Kidney Disease	☐ Skin Condition
☐ Asthma	☐ Diverticulitis	☐ Hepatitis	☐ Liver Disease	☐ Stroke
☐ Blood Clot	☐ Fibromyalgia	☐ High Cholesterol	☐ Mental Illness	☐ Thyroid Disease
☐ other				

Procedures & Surgeries: ☐ None ☐ YES. If so, please list all Procedures/Surgeries with dates below

Family History: (check all/any that apply) Unknown Negative Adopted

	Mother	Father	Sister	Brother	Other:	Other:
Anesthesia Allergy						
Arthritis						
Bleeding Condition						
Circulation Condition						
Depression						
Diabetes						
Cancer						
Foot Problems						
Heart Disease						
High Blood Pressure						
High Cholesterol						
Mental Illness						
Stroke						
Vascular Disease						
Other						

Social History:

Alcohol Use	Current	Past	Never
	Type and How Often:		
Tobacco Use	Current	Past	Never
	Type and How Often:		
Vaping	Current	Past	Never
	Type and How Often:		
E-Cigarette	Current	Past	Never
	Type and How Often:		
Street Drugs	Current	Past	Never
	Type and How Often:		
Physical Activity	Type and How Often:		

☐

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Are you currently experiencing any of the following:	**YES**	**NO**	**If yes, please explain**
General (chronic fever, unexpected weight loss/gain, fatigue	☐	☐	_____
Eye (double vision, glaucoma, vision loss, cataracts)	☐	☐	_____
Ear/Nose/Throat (hearing loss, sinus problems, dizziness)	☐	☐	_____
Heart (chest pains, irregular heartbeats, heart murmur)	☐	☐	_____
Respiratory (shortness of breath, wheezing, coughing)	☐	☐	_____
Gastrointestinal (heartburn, diarrhea, vomiting, abdomen pain)	☐	☐	_____
Urinary (frequent or painful urination, incontinence, blood in urine)	☐	☐	_____
Musculoskeletal (muscle aches, arthritis, swollen joints, gout)	☐	☐	_____
Skin (rashes, excessive dryness, sore, itching)	☐	☐	_____
Neurological (numbness, weakness, headaches, paralysis)	☐	☐	_____
Psychiatric (depression, anxiety)	☐	☐	_____
Endocrine (excessive hunger, thirst or sweating)	☐	☐	_____
Hematological/Lymphatic (anemia, bruising, bleeding problem)	☐	☐	_____

PATIENT PORTAL REGISTRATION

☐ **Please register me for the IQ Health Patient Portal**, allowing me to access my test results, request appointments and medication refills, update personal information, send and receive messages, and keep track of my health plan on the secure website. YOU MUST HAVE AN EMAIL ACCOUNT TO USE THIS SERVICE

- Use the last 4-digits of my SS# as my initial password: _____

or

- Use my postal zip code as my initial password: _____

☐ **Not Interested in IQ Health Patient Portal**

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Consent for Treatment

I give my consent for necessary medical and surgical treatment, and the use of anesthetics or any medications deemed necessary for my care as agreed upon by me and my medical provider during our consultations.

Insurance Authorization

In order to submit a claim for payment to us for services covered under your policy, we must have your authorization to release medical information to your insurance carrier. **Medicare:** I request that payment of the authorized Medicare benefits be made on my behalf to BRANDYWINE PODIATRY for any services furnished about me be that group of physicians. I authorize any holder of medical information about me to be released to the benefits payable for related services. I hereby authorize Medicare to furnish to BRANDYWINE PODIATRY any information regarding me Medicare claims under Title XVIII of the Social Security Act. **Commercial insurance:** I hereby authorize release of information necessary to file a claim with my insurance company and ASSIGN BENEFITS OTHERWISE PAYABLE TO ME TO THE GROUP INDICATED ON THE CLAIM. I understand I am financially responsible for any balance not covered by my insurance carrier. A copy of this signature is as valid as the original. As a service to you, our office will gladly submit any covered visits or procedures to your insurance company. After a 30 day period we will inquire as to the status of all unpaid claims. Again in 30 days, an inquiry will be made. If at any time we have no results from the insurance company, the account will then be payable by the patient. It is the patient's ultimate responsibility to be aware of their insurance plan. Many insurance plans require patients to obtain referrals from their Primary Care Physician to use particular labs, hospitals, etc. You as the subscriber are responsible for your policy.

Notice of Privacy Policies

I understand that, under the Health Insurance Portability & 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: (1) conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly; (2) obtain payment from third party payers; and/or (3) conduct normal healthcare operations such as the 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 the Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Privacy Practices. I understand that I may request in writing that you restrict how private information is used or disclosed to carry our 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 also 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 HAVE READ THE ABOVE AND I ACCEPT: CONSENT FOR TREATMENT, INSURANCE AUTHORIZTION, AND NOTICES OF PRIVACY POLICIES.

SIGNATURE: **Today's Date: / /**

Relationship to patient being treated today (circle one): SELF OTHER (if other, how are you related?): _____

The individual whose signature appears above hereby attests to the following statements: With my consent, BRANDYWINE PODIATRY, LLC may disclose my PHI to the following individuals (family, relatives, or friends) who may assist in my care:

NAME	RELATIONSHIP	HOME #	CELL #