NEW PATIENT REGISTRATION FORM

ADVANCED FOOTCARE CENTER

DAVID M. VELARDE, DPM
2824 MERCHANT DR. KNOXVILLE, TN 37912 (MAIN LOCATION)
1610 TAZEWELL RD. SUITE 304 TAZEWELL, TN 37879
PHONE: 865-523-1141
FAX: 865-521-6635
WWW.KNOXVILLEFOOTDOCTOR.COM

Demographics: Today's Date: ____/____/_____

Patient name: Last _____ First _____ MI_____

Date of Birth: ____/____/_____ Sex: Male / Female SSN:____-____-_____

Race: _____ Ethnicity: _____

Marital Status *(circle)*: Single / Married / Unmarried / Widowed / Divorced / Separated / _____

Spouse/Partner Name:_____ DOB: _____ Phone:_____

Is the patient being seen at a pain clinic? Yes / No

Contact Information:

Cell Phone:_____ Work Phone:_____ Home Phone: _____

Email:_____ Preferred phone? Cell / Work / Home

Is it OK to leave a detailed message? Yes / No Would you like to receive texts? Yes / No

Preferred Contact Method (choose one): Patient Portal / Phone / Email / Letter / Fax / Decline

Home Address: _____ City: _____ ST:_____

Zip:_____

Emergency Contact

Name: _____ Phone: _____Relationship to patient: _____

Address: _____ City: _____ ST:_____ Zip:_____

Employment ☐ Retired ☐ Unemployed

Patient Employer:_____ Employer Phone:_____

Occupation:_____ Sit or Stand: *how long?* _____

For Patients Under 18 Years

Parent/Legal Guardian's name:_____ DOB:_____

Do you have any of the following? Check all that are applicable

☐ Blood thinners
☐ Pacemaker
☐ Defibrillator
☐ Premedication prior to procedures
☐ Allergy to latex
☐ Allergy to shellfish and/or iodine
☐ Allergy to adhesive
☐ Pregnancy or planning a pregnancy
☐ Joint pains
☐ Joint stiffness
☐ Unsteady gait
☐ Numbness
☐ Tingling
☐ Poor healing wounds
☐ None of these apply

MEDICAL HISTORY

HEIGHT: _____'_____"
WEIGHT: _____lbs
SHOE SIZE: _____

Current foot issues:

Which foot is bothering you? ☐ RIGHT ☐ LEFT ☐ BOTH

Specify areas: HEEL / TOES / ARCH / SOLE OF FOOT / TOENAILS / OTHER: _____

Describe your foot problem: _____

_____

Have you tried anything to treat the problem? ☐ NO ☐ YES

Have you seen another physician for this issue? ☐ NO ☐ YES Physician's name: _____

How long has it been bothering you?

☐ Constantly / ☐ On and off *for* ☐ Days / ☐ Weeks / ☐ Months / ☐ Years / ☐ Chronic condition

Medications:

☐ I have a separate medication list ☐ I do not take any

Please list all **medications** you are taking and their doses, including **over the counter** medications and vitamins/supplements.

_____

_____

_____

_____

Allergies to medications: _____

_____

☐ No known allergies ☐ Latex ☐ Penicillin ☐ Codeine ☐ Sulfa ☐ Others: _____

_____

Local pharmacy: ☐ I do not currently have one

Name:_____ Location:_____ Phone:(_____) _____ _____

Surgical history: ☐ None ☐ Pacemaker ☐ Joint replacement - please write which joint(s)

Surgeries:_____

_____

Primary care physician:

Location:_____ Name of physician:_____

Social History:

Do you smoke cigarettes? ☐ Never ☐ Previously smoked ☐ Yes _____ packs per _____ day/s

Do you vape nicotine? ☐ Never ☐ Previously vaped ☐ Yes, daily ☐ Yes, socially

Do you drink alcohol? ☐ Never ☐ Occasionally ☐ Socially ☐ Yes, daily. Drinks per day:_____

Do you use recreational drugs? ☐ No ☐ Yes:_____

Do you have or have had any of the following conditions? (Check all that apply)

Medical History:

☐	None of these apply	☐	DM - Diabetes
☐	Arthritis	☐	Elevated Blood Pressure
☐	Asthma	☐	End-stage Renal Disease
☐	Atrial Fibrillation	☐	High cholesterol
☐	COPD	☐	Stroke
☐	Coronary Heart Disease	☐	Other: _____

Podiatric History:

☐	None of these apply	☐	Ankle Ulcer
☐	Chronic pain	☐	Venous Insufficiency (Bad circulation)
☐	History ofDeep venous thrombosis (blood clots)	☐	Ulcer of foot
☐	Hallux Valgus (bunions)	☐	Other: _____
☐	Neuropathy	☐	Other: _____
☐	Vascular disease	☐	Other: _____

☐ Not pregnant ☐ Pregnant: _____ weeks ☐ Menopause

Special Needs:

☐ Autism ☐ Down Syndrome ☐ Dementia ☐ Alzheimer's ☐ Other:_____

Family History:

	Father ☐ deceased ☐ alive	Mother ☐ deceased ☐ alive
Arthritis	☐	☐
Heart disease	☐	☐
Diabetes	☐	☐
High blood pressure	☐	☐
Bleeding disorders	☐	☐
Cancer	☐	☐
Anesthesia problems	☐	☐

I, _____ **(print name)**, certify that the above information is true and correct to the best of my knowledge. I give my permission to **Dr. David Velarde** to administer and perform the procedures he deems necessary in the diagnosis and/or treatment. I understand that perfect results cannot be guaranteed.

_____ _____ _____

Printed name of Patient or Parent/Legal guardian | Signature of Patient or Parent/Legal Guardian | Date

ADVANCED FOOT CARE CENTER
DAVID M VELARDE DPM
865 523 1141

PATIENT PRIVACY FORM

The Department of Health and Human Services has established a "Privacy Rule" to help ensure that personal health care information is protected for privacy. The Privacy Rule was also created in order to provide a standard for certain health care providers to obtain their patient's consent for uses and disclosures of health information about the patient to carry out treatment, payment or health care operations.

As our patient, we want you to know that we respect the privacy of your personal medical records and will do all we can to secure and protect that privacy. We strive to always take reasonable precautions to protect your privacy. When it is appropriate and necessary, we provide the minimum necessary information to only those we feel are in need of your health care information and information about treatment, payment, or healthcare operations, in order to provide health care that is in your best interest.

We also want you to know that we support your full access to your personal medical record. We may have indirect treatment relationships with you (such as laboratories for purposes of treatment, payment, and not patients) and may have to disclose personal health information for purposes of treatment, payment, or health care operations. The entities are most often not required to obtain patient consent.

You may refuse to consent to the use or disclosure of your personal health information. Under this law, we have the right to refuse to treat you should you choose to refuse to disclose your Personal Health Information (PHI). If you choose to give consent in this document, you may, at some future time, request to refuse all or part of your PHI. You may not revoke actions that have already been taken which relied on this or previously signed consent.

If you have any objections to this form, please ask to speak with our HIPPA Compliance Officer.

You have the right to receive a copy of our privacy notice, to request restrictions and revoke consent in writing after you have received our privacy notice.

COMPLIANCE ASSURANCE NOTIFICATION FOR OUR PATIENTS

The misuse of Personal Health Information (PHI) has been identified as a national problem causing patients inconvenience, aggravation, and money. We want you to know that all our employees, managers, and doctors continually undergo training so they may understand and comply with government rules and regulations regarding the Health Insurance Portability and Accountability Act (HIPPA) with particular emphasis on the "Privacy Rule". We strive to achieve the very highest standards of ethics and integrity in performing services for our patients.

It's our policy to properly determine appropriate uses of PHI in accordance with the governmental rules, laws, and regulations. We want to ensure that our practice never contributes in any way to the growing problem of improper disclosure of PHI. As part of this plan we have implemented a Compliance program that we believe will help us prevent any inappropriate use of PHI.

We also know that we are not perfect! Because of this fact, our policy is to listen to our employees and our patients without any thought of penalization if they feel that an event in any way compromises our policy of integrity. More so, we welcome your input regarding any service problem so that we may remedy the situation promptly. Thank you for being one of our highly valued patients.

I_____ hereby authorize Advanced Foot Care Center to disclose my personal health information to the following individual(s):

_____

ADVANCED FOOT CARE CENTER is also authorized to leave messages on the following:

☐ Home Phone ☐ Cell Phone ☐ Email

_____ _____

Patient/Parent/Guardian Date

Advanced Foot Care Center

David M. Velarde DPM

(865)523-1141

Assignment of Benefits and Release

I, the undersigned, certify the I (or my dependent) have insurance coverage with:

_____

_____

And assign directly to Advanced Foot Care Center, PC and /or David Velarde all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether paid by insurance such as (co-pays, deductibles, and/or co-insurance). I hereby authorize the doctor to release all information necessary to secure payment of benefits. I authorize the use of this signature on all insurance submissions.

_____ Date: _____

Signature of patient/responsible party

_____

Relationship to patient

For Medicare Patients Only:

Medicare Authorization

I request payment of authorized Medicare Benefits be made either to me or on my behalf to advanced Foot Care Center. PC and/or David Velarde DPM for services furnished me by that physician. I authorize any holder of medical information about me to release to the Heath Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature request that my [payment be made and authorize any information necessary to pay this claim. If "other health insurance" is indicated in item 9 of HCFA 1500 form, or elsewhere on other approved claims forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and any non-covered services. Coinsurance and deductible are based upon the charge determination of the Medicare carrier.

_____ Date: _____

Signature of patient/responsible party

_____

Relationship to patient