LAFAYETTE PODIATRY ASSOCIATES * 2020 UNION STREET, SUITE 100 * LAFAYETTE, IN 47904

Patient Information:

Patient Name: ____ **Gender**: ❑M ❑ F
First Middle Last

SSN: ____________ **DOB**: ____________ **Email**: ____________________

Mailing Address: ____
Street City State Zip Code

Home Phone: (________) ________-________ **Work Phone**: (________) ________-________

Cell Phone: (________) ________-________ **Upon contact, whom may we speak with**: Patient | Spouse | Parent

Employer: ____________________ **Employer Phone**: (________) ________-________

Emergency Contact: ____________________ **Relationship to patient:** ____________________

Emergency Phone: (________) ________-________

Does the patient have a POWER OF ATTORNEY? YES❑ NO❑ (If yes, please ask for corresponding paperwork.)

Government Mandated Information: (ALL fields required) Primary Language: ____________________

Race: American Indian | Asian | Pacific Islander | African American | Caucasian **Ethnicity**: Hispanic/Latino | Non-Hispanic/Non-Latino

Marital Status: Single | Mar | Div | Wid **Student Status**: Part-time | Full-time | N/A **Employment Status**: Part-time | Full-time | N/A

Insurance Information: (ALL fields required if policy holder is not the patient, if policy holder is the patient simply circle self)

Primary Insurance Company: ____________________ **Policy Holder's Name**: ____________________

Birthdate: ____________ **Policy holder's relationship to patient: Self | Father | Mother | Spouse | Other** ________

Secondary Insurance Company: ____________________ **Policy Holder's Name**: ____________________

Birthdate: ____________ **Policy holder's relationship to patient: Self | Father | Mother | Spouse | Other** ________

If patient is a minor, who is financially responsible for services and/or products provided? (Please complete section below)

Name: ____________________ **DOB:** ____________ **Phone:** ____________

Mailing Address: ____
Street City State Zip Code

Attention:

- I authorize the release of all information to my insurance companies, workers compensation carriers, and/or other treating physicians.
- I authorize and request insurance payment directly to Lafayette Podiatry Associates, P.C.
- I understand that I am responsible for my bill.
- I authorize use of this form on all of my insurance submissions.
- I authorize Lafayette Podiatry Associates, P.C. to act as my agent in helping obtain payment from my insurance companies and to help me obtain any required pre-certification.
- I agree to pay for my bill in full plus court costs, attorney fees, and all collection fees if deemed necessary.
- If insurance deems my procedure medically unnecessary, I will be responsible for payment.
- I authorize the physicians of Lafayette Podiatry Associates, P.C. to treat my foot/ankle problems.

____ ____________________

PATIENT/PARENT SIGNATURE **DATE**

Medical History

Patient Name: ____ **DOB:** _____________________

Height: __________ **Weight:** ____________ **Shoe size:** __________ **Do you have Diabetes?** Y N

Primary Physician: ____________________________ **Referring Physician:** _____________________

Pharmacy & Location: ____

Do we have permission to access your medication history from your pharmacy? Y N
(If you do not allow access, you must provide a list of all mediations you are currently taking.)

What type of foot/ankle problem are you having? ____

____

Do you exercise or participate in any types of sport activities, what type? ___________________________

____

Social History:

Do you smoke?	**Packs per day:**	**Number of Years:**	**Do you use alcohol?**	**If yes, how often?**
Y N	_______	_________	Y N	Rarely Often Socially

Medical History: (please check all that apply)

Arthritis	**Cancer**	**Gout**	**Heart Attack**	**Hepatitis**
High Cholesterol	**HIV/Aids**	**Injury/Fracture**	**Osteoporosis**	**Stroke**
Rheumatoid Arthritis	**Diabetes 1 or 2**	**Ulcers**	**High Blood Pressure**	**Kidney Disease**
Thyroid Disease	**Other**	**Other**	**Other**	**Other**

Surgical History:

Allergies:

____ _________________________

PATIENT/PARENT SIGNATURE **DATE**

2020 Union Street, Suite 100
Lafayette, IN 47904
Phone (765) 449-4758
Fax (765) 449-0659
www.lafayettepodiatry.com

I ______________________________________ give permission for Lafayette Podiatry
(Patient Name)
Associates, P.C. to release any information related to: (Please check all that apply)

- ☐ My Appointments ☐ Billing Information ☐ Medical Information

This information may be released to:

- ☐ My spouse: ____
(Spouse Name)
- ☐ My POA: ____
(POA Name)
- ☐ Other: _________________________________ _____________________________
(Name) (Relationship)

- ☐ I do not authorize my information to be released to anyone.

Authorization date: ____

Patient Signature: ____

Office Staff Witness: ____

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Lafayette, IN 47904
Phone (765) 449-4758
Fax (765) 449-0659
www.lafayettepodiatry.com

ACKOWLEDGEMENT OF RECEIPT OF

NOTICE OF PRIVACY PRACTICES

I acknowledge that I was offered a copy of the Notice of Privacy Practices and that I have read or had the opportunity to read if I so choose. I understand and agree to the terms in the notice.

(If you would like a copy of the notice for your records, please inform the front desk staff)

______________________________________ _________________________
Patient Name (Please Print) Date

____
Signature

____
Parent or Authorized Representative (if applicable)

For office use only:

On __________________, __________________________________ presented this
Date Employee Signature

Acknowledgement of Receipt of Notice of Privacy Practices Form to

_________________________. The patient refused to provide a signature when requested.