Family Foot & Ankle Specialists

Date: _____/_____/_____

Patient Name: _____ Date of Birth: _____/_____/_____ Sex: ◯ M ◯ F

Home Address: _____ City/State: _____

ZIP: _____ E-Mail: _____ Home Phone: (_____) _____-_____

Cell Phone: (_____) _____-_____ Marital Status: ◯ Single ◯ Married ◯ Divorced ◯ Widow(er)

Primary Care Doctor Name: _____ Date Last Seen: _____

Primary Care Doctor Phone/Address: _____

Preferred Pharmacy: _____ Location: _____

Pharmacy Phone: (_____) _____-_____

Primary Language: _____ Ethnicity: _____ Race:_____

Emergency Contact: _____ Phone: (_____) _____-_____ Relation: _____

How did you find Dr. Baird? _____

INSURANCE INFORMATION

Insured Name: _____ Date of Birth: _____/_____/_____ Employer: _____

▸ **Primary** Insurance Company Name: _____

Address: _____ City/State: _____ ZIP: _____ Phone: (_____) _____-_____

ID # _____ Group # _____

▸ **Secondary** Insurance Company Name: _____

Address: _____ City/State: _____ ZIP: _____ Phone: (_____) _____-_____

ID # _____ Group # _____

ASSIGNMENT AND RELEASE

I, the undersigned have _____ insurance, and assign directly to James Baird D.P.M. all medical benefits, if any, otherwise payable to me for any services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions.

Signature of Insured/Guardian _____ **Date:** _____

MEDICARE AUTHORIZATION

I request that payment of authorized Medicare benefits to be made to James Baird D.P.M. for any services furnished to me by that physician. I authorize any holder of medical information about me to be released to the Healthcare Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay this claim. If “other health insurance” is indicated in item 9 of the HCFA-1500 form, or elsewhere on other approved claim 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 the Medicare carrier as full charge, and the patient is responsible only for the DEDUCTIBLE, COINSURANCE, and NONCOVERED SERVICES. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

Signature of Insured/Guardian _____ **Date:** _____

PATIENT HISTORY

Name: _____

What brings you to Dr. Baird? _____

_____

ALLERGIES ☐ None Known

☐ Medication Allergies: _____

☐ Anesthesia Allergies: _____

☐ Food Allergies: _____

☐ Other: _____

MEDICATION

Please list all medication you are currently taking (including prescriptions, over-the-counter meds and herbal supplements):

NAME	DOSE	NAME	DOSE
_____		_____	
_____		_____	
_____		_____	
_____		_____	
_____		_____	

PAST MEDICAL HISTORY

Have you ever had any of the following? (Please check all that apply):

☐ Acid Reflux	☐ Aneurysm	☐ Bladder Infections	☐ Cancer
☐ Diabetes /HbA1C_____	☐ Heart Attack	☐ Hepatitis	☐ High Blood Pressure
☐ HIV/AIDS	☐ Kidney Disease	☐ Liver Disease	☐ Open Sores
☐ Stroke	☐ Rheumatic Fever	☐ Skin Disorder	☐ Stomach Ulcers
☐ Varicose Veins	☐ Other_____		

Please list all prior surgeries:

TYPE OF SURGERY	DATE
_____	
_____	
_____	
_____	
_____	

Shoe Size: _____ Height: _____ Weight: _____

CONSTITUTIONAL:

- [ ] Chills
- [ ] Fatigue
- [ ] Migraine Headaches
- [ ] Sleep Apnea
- [ ] Other: _____

_____

CARDIOVASCULAR:

- [ ] Angina
- [ ] Atherosclerosis
- [ ] Blood Clot
- [ ] Chest Pain
- [ ] Heart Attack
- [ ] Heart Disease/Failure
- [ ] High Blood Pressure
- [ ] High Cholesterol
- [ ] Irregular Beats/Palpitations
- [ ] Leg Pain at Rest
- [ ] Leg Pain While Walking
- [ ] Low Blood Pressure
- [ ] Mitral Valve Prolapse/Murmur
- [ ] Pacemaker
- [ ] Phlebitis
- [ ] Other: _____

_____

ENDOCRINE:

- [ ] Diabetes
- [ ] Thyroid Disease
- [ ] Other: _____

_____

LYMPHATIC:

- [ ] Abnormal Bleeding
- [ ] Anemia
- [ ] Blood Transfusion
- [ ] Sickle Cell Disease
- [ ] Other: _____

_____

MUSCULOSKELETAL:

- [ ] Arthritis
- [ ] Back Trouble
- [ ] Fibromyalgia
- [ ] Gout
- [ ] Joint Pain
- [ ] Muscle Tendon/Pain
- [ ] Rheumatoid Arthritis
- [ ] Other: _____

_____

NEUROLOGICAL:

- [ ] Neuropathy
- [ ] Polio
- [ ] Seizures
- [ ] Stroke
- [ ] Other: _____

_____

PSYCHIATRIC:

- [ ] Anxiety
- [ ] Depression
- [ ] Memory Loss
- [ ] Paranoia
- [ ] Other: _____

_____

RESPIRATORY:

- [ ] Asthma
- [ ] Bronchitis
- [ ] Collapsed Lung/Atelectasis
- [ ] Emphysema
- [ ] Lung Cancer
- [ ] Pneumonia
- [ ] Shortness of Breath
- [ ] Tuberculosis
- [ ] Valley Fever
- [ ] Other: _____

_____

SOCIAL HISTORY

Tobacco Use: [ ] Never [ ] Former [ ] Sometimes [ ] Everyday

If current smoker, how often?: [ ] Less than 5 cigarettes per day [ ] ½ pack per day [ ] 1 pack per day [ ] More than a pack per day

Alcohol Use: [ ] Non-Drinker [ ] Social [ ] Moderate [ ] Heavy [ ] Recovering Alcoholic

FAMILY HISTORY

(Please write who had each problem next to it (for example: Mother, Father, Brother, Sister, Son, Daughter)

[ ] Cancer _____ [ ] Diabetes _____ [ ] Heart Attack _____

[ ] Heart Disease/Failure _____ [ ] High Cholesterol _____

[ ] High Blood Pressure _____ [ ] Thyroid Disease _____

[ ] Other _____

Family Foot & Ankle Specialists

Dr. James Baird
1410 S. Barrington Road
Barrington, IL 60010
(847) 381-5011

Authorizations for Use and Disclosure of Protected Health Information

Name: _____

Date of Birth: _____/_____/_____ Preferred Phone: (_____) _____-_____

Please choose ONE option:

☐ I want my test results/protected health information reported directly to me only.

OR

☐ Family Foot and Ankle Specialists has my permission release/disclose test results/protected health information to any individual listed below:

NAME	RELATIONSHIP	PHONE NUMBER
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____

May we leave medical information on your answering machine/voice mail? ☐ Yes ☐ No

May we leave a reminder call message on your answering machine/voice mail? ☐ Yes ☐ No

_____ _____

Signature Relationship to patient

_____/_____/_____

Date

PRIVACY NOTICE

Right to Notice: As a patient, you have the right to adequate notice of the uses and disclosures of your protected health information. Under the Health Insurance Portability and Accessibility Act **(HIPPA)**, Dr. James Baird can use your protected health information for treatment, payment and health care operations.

a. **Treatment:** We may use or disclose your health information to a physician or other health care provider providing treatment to you.
b. **Payment:** We may use and disclose your health information to obtain payment for services we provide you.
c. **Health care operations:** We may use and disclose your health information in connection with our health care operations. Health care operations include quality assessment and improvement activities, reviewing the competency or qualifications of health care professionals, evaluating provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.
d. **Business Associates:** We provide some services through other persons or companies that need access to your health information to carry out theses services. The law refers to these third parties as “business associates” (e.g. billing, transcription services). Our business associates and their subcontractors are enter into written contract to protect the privacy of your protected health information and comply with the HIPAA Privacy Rule to the extent that the business associates carries out the practitioner's obligations under the Privacy Rule. We require that they use appropriate safeguards to protect electronic protected health information. Our business associates must report any breaches of your protected health information.

Your Authorization: Most uses and disclosures that do not fall under treatment, payment, health care operations will require your written authorization. Upon signing, you may revoke your authorization (in writing) through our practice at any time.

Emergency Situations: In the event of your incapacity or an emergency situation, we will disclose health information to a family member, or another person responsible for your care, using our professional judgment. We will only disclose health information that is directly relevant to the person's involvement in your health care.

Marketing: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may also use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your or other people's health or safety.

National Security: We may disclose the health information of Armed Forces personnel to military authorities under certain circumstances. We may disclose health information to authorized federal officials required for lawful intelligence, counterintelligence and other national security activities. We may disclose health information of inmates or patients to the appropriate authorities under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders via phone, e-mail or letter.

Your Rights as a Patient: You have the right to restrict the disclosure of your protected health information (in writing). The request for restriction may be denied if the information is required for treatment, payment or health care operations. You have the right to receive confidential communications regarding your protected health information. You have the right to inspect and to obtain a copy your protected health information. Upon request we have the right to charge per staff hour, copy and postage fees to locate, copy and mail your protected health information. You have the right to obtain your protected health information in electronic format. You have the right to direct the practice to transmit an electronic and/or paper copy directly to a third party upon your request. You have the right to amend your protected health information. You have the right to receive an account of disclosures of your protected health information. You have the right to a paper copy of this notice of privacy practices. You have the right to be notified of an unauthorized disclosure of your protected health information. You have the right to request the practitioner to withhold insurance information from an insurance company if you pay out of pocket in full for the service.

Legal Requirements: James A. Baird D.P.M., P.C. is required by law to maintain the privacy of your protected health information. We are required to abide by the terms of this notice as it is currently stated, and reserve the right to change this notice. The policies in any new notice will not be in effect until they are posted to this site, or are available within our office.

Complaints: If you have complaints regarding the way your protected health information was handled, you may submit a complaint in writing to our office. You also may submit a written complaint to the U.S. Department of Health and Human Services. You will not be retaliated against in any manner for a complaint.

Signature of acknowledgment of Notice of Privacy Practice:

_____ Date: _____/_____/_____