Practice: ADVANCED PODIATRY ASSOC, LLC **Today's Date:**

Name: ____________________ **Chart #:** ________ **Date of birth:** ________

Race: ____________________ ☐I prefer not to answer ☐I do not know

(White, American Indian, Asian, Black or African, Native Hawaiian, Hispanic, etc.)

Ethnicity: ____________________ ☐I prefer not to answer ☐I do not know

Preferred Language: ____________________ ☐I prefer not to answer

Pharmacy Name: ____________________ **Pharmacy Phone:** ____________

Pharmacy Address: ____________________ City, State, Zip: ____________

Primary Care Physician: ____________ Phone: ________ Date Last Seen: ________

Address: ____________________

Referring Physician: ____________ Phone: ________ Date Last Seen: ________

Address: ____________________

Privacy Information Preferences

Do you want to be exempt from public reporting? ☐Yes ☐No Can we send mail to the address on file? ☐Yes ☐No

Can we call the phone number on file? ☐Yes ☐No Can we leave voicemail on machine? ☐Yes ☐No

Will you allow us to send internet based (e-mail) delivery of reminders and newsletters? ☐Yes ☐No

If yes, please provide your e-mail address: ____________________

Who can we leave messages with? ☐Wife ☐Husband ☐Daughter ☐Son ☐Other: ____________

Name(s): ____________________

Smoking Status

☐ Current Every Day Smoker ☐ Never Smoker

☐ Current Some Day Smoker ☐ I decline to answer

☐ Former Smoker

Vital Signs

Blood Pressure: ______ / ______

Height: ________ Weight: ________

Current Medications

☐ No Known Medications ☐ I take the following medications:

Name: ____________ Dose: ______

Name: ____________ Dose: ______

Name: ____________ Dose: ______

Name: ____________ Dose: ______

Name: ____________ Dose: ______

Name: ____________ Dose: ______

Name: ____________ Dose: ______

Name: ____________ Dose: ______

Name: ____________ Dose: ______

Use the back of this form if more room is needed

Allergies

☐ No Known Allergies ☐ No Known Drug Allergies

Name: ____________ Reaction: ______

Name: ____________ Reaction: ______

Name: ____________ Reaction: ______

Name: ____________ Reaction: ______

Name: ____________ Reaction: ______

Name: ____________ Reaction: ______

Name: ____________ Reaction: ______

Name: ____________ Reaction: ______

Name: ____________ Reaction: ______

PLEASE READ AND SIGN: The information on my intake form(s) is correct to the best of my knowledge. I understand that throughout my treatment, I am responsible for notifying the physician and/or medical staff of any and all updates to the information listed above. *(Assignment of Benefits)*: I authorize payment of medical benefits to the practice named above. *(Release of Information)*: I authorize the release of any medical information necessary to process this claim. *(HIPAA Privacy)*: I acknowledge that I received my HIPAA Privacy Practices Notice. *(Medication History)*: I authorize the Doctor's office to retrieve my medication history.

Patient Signature: ____________________ Date: ____________

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