Dr. Ronald Sheppard DPM, FACFAS
Board Certified Foot Surgeon
Diplomate-American Board of Podiatric Surgery

NAME:_____ **SEX: M F**

ADDRESS:_____

TOWN:_____ **ZIPCODE:**_____

HOME PHONE #:_____ **CELL PHONE #:** _____

SSN #: _____-_____-_____ **BIRTHDATE:** _____

MARITAL STATUS: S M D W

OCCUPATION:_____

E-MAIL ADDRESS: _____

Primary Language_____ **Race**_____ **Ethnicity: Are you Hispanic or Latino:** Y N

PHARMACY NAME: _____ **LOCATION:** _____ **PHONE:** _____

WHAT IS THE MAIN REASON FOR YOUR VISIT TODAY?

_____

HOW WERE YOU REFERRED TO THE OFFICE?

[ ] Internet/Google [ ] Facebook [ ] Insurance Referral [ ] Doctor Referral: _____

[ ]Friend/Family: _____ [ ] Other: _____

PRIMARY INSURANCE:

INSURANCE COMPANY_____

NAME OF CARD HOLDER_____

ID NUMBER: _____ GROUP NUMBER_____

INSURED BIRTHDATE _____

INSURED SOCIAL SECURITY #_____

SECONDARY INSURANCE:

INSURANCE COMPANY NAME:_____

NAME OF CARD HOLDER_____

ID NUMBER: _____ GROUP NUMBER_____

INSURED BIRTHDATE :_____

INSURED SOCIAL SECURITY # :_____

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NAME_____ **DOB**_____

PATIENT HISTORY

Sex M F
Height_____ Weight_____
Last Known Blood Pressure _____/_____

Do you smoke? Current Former Never
If yes, how much?_____

Do you drink alcohol? YES NO
If yes, how much?_____

Are you being treated for or have you ever been treated for (please check all that apply):

_____**High Blood Pressure (Hypertension)**
_____**Diabetes**
_____Asthma
_____Syncope (Fainting issues)
_____Thyroid Conditions
_____Liver Disease or Hepatitis
_____High Cholesterol
_____Heart Trouble (CAD)
_____Kidney Disease
_____Circulation Issues (PVD)
Other (please list): _____

Have you had any past **SURGERIES**? **YES NO**

If yes, what type and when? (please list)

SURGERY	**Date**
_____	_____
_____	_____
_____	_____

Do you have a PRIMARY CARE PHYSICIAN? Yes____ No____
Name:_____

Address:_____

Phone #:_____

Date last seen:_____

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List all medications you are presently taking:

Medication:	**Amount/Frequency:**
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Are you subject to **prolonged bleeding** ? **YES** **NO**
If **yes**, do you take a blood thinner? (I.E Coumadin or Aspirin) **YES** **NO**

Do you have any **ALLERGIES** to drugs, medicines, or other substances? **YES** **NO**
Is **yes**, please list: _____

We are required by the government ACA Act to ask the following questions for data collection:

If you are 65 years old or older have you received your **PNEUMONIA VACCINE** within the last 5 years? **YES** **NO** **DOES NOT APPLY**

If you are 50-75 years old have you had a COLORECTAL CANCER SCREENING?
YES **NO** **DOES NOT APPLY**

If **YES** was it (please circle): **COLONOSCOPY** or **FLEX. SIGMOIDOSCOPE ?**

Have you had your **FLU SHOT**? **YES** **NO**
If **yes**, when? _____

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MEDICAL INSURANCE AUTHORIZATION

SIGNATURE ON FILE

- I authorize use of this form on all my insurance submissions.
- I authorize release of necessary information to all my insurance carriers.
- I authorize my doctor's staff to act as my agent in helping me obtain payment from my insurance carrier.
- I authorize payment from my insurance carrier directly to my doctor.
- I permit a copy of this authorization to be used in place of the original.

Patient's Name: _____

Signature: _____

Date: _____

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ACKNOWLEDGMENT OF RECEIPT

OF

NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read if I so chose) and understood the notice.

_____ _____

Patient Name (please print) Date

_____

Signature

Relationship to patient:

Self: _____

Parent: _____

Authorized representative:_____

I give permission to the following person to access my medical records:
Name: _____
Relationship to patient: _____