Foot Specialists of South Mississippi

Phone: (228) 818-2801
Fax: (228) 818-2803

Dr. Ricky Roach

PATIENT INFORMATION

First Name _____ Middle Initial _____ Last Name _____ Suffix _____

Date of Birth _____

Address _____ City _____ State _____ Zip Code _____

Phone Number (_____) _____

PARENT INFORMATION

Name(s) _____ Contact Number (_____) _____

Address _____ City _____ State _____ Zip Code _____

Employer _____ Job Title _____

☐ Full Time ☐ Part Time ☐ Retired ☐ Self-Employed ☐ Not Employed

EMERGENCY CONTACT

Name _____ Relationship to Patient_____ Phone Number(____) _____

INSURANCE INFORMATION

Primary Policy:
Insurance Carrier _____

ID/Policy Number _____

Name of Policy Holder _____

Date of Birth of Policy Holder _____

Relationship to Patient _____

Secondary Policy:
Insurance Carrier _____

ID/Policy Number _____

Name of Policy Holder_____

Date of Birth of Policy Holder _____

Relationship to Patient _____

VISIT INFORMATION

1. Why is your child seeing the doctor today? _____

2. Does your child have any pain associated with the condition? ☐ Yes ☐ No

3. Any additional factors you would like to mention? _____

3. Whom may we thank for your child's referral today? _____

4. Name of Pediatrician or Primary Care Physician (PCP): _____

5. Preferred Pharmacy Information: _____

PAST MEDICAL HISTORY:

Height _____ Weight _____ Shoe Size _____

Does your child have OR has your child ever had any of the following conditions:

Constitutional/General
☐ Cancer Type_____
☐ Leukemia
☐ Chronic illness
☐ Elevated temperature
☐ Night sweats
☐ Tires easily

Cardiovascular
☐ Blood clots/ DVT
☐ Easy bruising/bleeding
☐ Irregular heart beat
☐ Poor circulation
☐ Rheumatic fever
☐ Valve problems

Liver
☐ Hepatitis
☐ Jaundice

Skin
☐ Birth marks
☐ Rashes

Hematologic Disease
☐ Anemia Type _____
☐ Sickle Cell

Respiratory
☐ Asthma
☐ Bronchitis
☐ Chronic Cough
☐ COPD

Gastrointestinal
☐ Bladder or kidney stones
☐ Infection
☐ Kidney Disease

Endocrine
☐ Diabetes
☐ Heat or Cold intolerance
☐ Cushing's or Addison's

Infectious Disease
☐ HIV/AIDS
☐ TB/Tuberculosis
☐ STDs

Musculoskeletal
☐ Arthritis
☐ Deformity
☐ Fracture
☐ Pain

Genito-Urinary
☐ Bladder or kidney stones
☐ Infection
☐ Kidney disease

Special Senses
☐ Double/blurred vision
☐ Contacts/Glasses
☐ Ear Infections
☐ Hearing deficit/loss

Nervous System
☐ Anxiety
☐ Autism
☐ Convulsions/epilepsy
☐ Depression
☐ Fainting
☐ Migraines
☐ Muscular dystrophy
☐ Muscular sclerosis
☐ Paralysis
☐ Speech Problems
☐ **Other:** _____
_____

FAMILY HISTORY

Please indicate known medical history of child's relatives (i.e. diabetes, heart disease, glaucoma, etc.)

Mother _____

Father _____

Siblings _____

Maternal Grandparents _____

Paternal Grandparents _____

MEDICATIONS

Please include prescriptions, over the counter, vitamins and supplements.

- You may also submit a current medication list

Medication	Dosage	Frequency	Medication	Dosage	Frequency

ALLERGIES

Please indicate all allergies, including those to medication and food.

Medications: **Non-Medications:**

☐ **No Known Drug Allergies**

Medication	Reaction		

SURGICAL and HOSPITALIZATION HISTORY

Surgeries (please include type and year) _____

Any complications due to anesthesia? ☐ Yes ☐ No Describe _____

Hospitalizations (other than birth; include reason and year) _____

SOCIAL and IMMUNIZATION HISTORY

What School is Child Enrolled at? _____ Grade Level _____

Child's interests (hobbies, sports, etc.) _____

Does your child have any learning, school, and/or social issues? _____

Child's Parents are: ☐ Married ☐ Separated ☐ Divorced ☐ Deceased ☐ Other

Are child's immunizations (tetanus, diphtheria, pertussis, etc.) current? ☐ Yes ☐ No

If Yes: When was child's last Tdap Booster? _____ When was child's last MMR Booster? _____

Has child received the: Most recent flu shot? ☐ Yes ☐ No Pneumonia Vaccine? ☐ Yes ☐ No

Hepatitis B Vaccine? ☐ Yes ☐ No Other Elective Vaccines? ☐ Yes ☐ No

PATIENT HIPAA ACKNOWLEDGEMENT AND DESIGNATION DISCLOSURE FORM

I. Acknowledgement of Practice's *Notice of Privacy Practices:*
By subscribing my name below, I acknowledge that I was provided a copy of the Notice of Privacy Practices (NPP), and that I have read (or had the opportunity to read if I so chose) and understand the Notice of Privacy Practices (NPP) and agree to it's terms.

Name of Patient	Date of Birth	Signature of Parent/Guardian	Date

II. Designation of Certain Relatives, Close Friends and/or Caregivers as my Personal Representative:
I agree that the practice may disclose parts of my health information to a Personal Representative of my choosing, since such person is involved with my healthcare and/or payment relating to my healthcare. In that case, the Physician/Practice will disclose only information that is directly relevant to the person's involvement with my healthcare or payment relating to my healthcare.

Print Name: _____ DOB or Other Identifier: _____

Print Name: _____ DOB of Other Identifier: _____

III. Request to Receive Confidential Communications by Alternative Means:
As provided by Privacy Rule Section 164.522(b), I hereby request that the Practice make all communications to me as I have listed below:

Home Telephone Number:

☐ Okay to leave a message with detailed information **- OR -** ☐ Leave message with call back number only

Work Telephone Number:

☐ Okay to leave message with detailed information - **OR** - ☐ Leave message with call back number only

Cell Telephone Number:

☐ Okay to leave message with detailed information - **OR** - ☐ Leave message with call back number only

EMAIL: _____ ☐ Okay to email address Practice has on file

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1. The above authorizations are voluntary and I may refuse to their terms without affecting any of my rights to receive healthcare at the Practice
2. These authorizations may be revoked at any time by notifying the Practice in writing at the Practice's mailing address marked to the attention of "HIPAA Compliance Officer."
3. The revocation of this authorization will not have any effect on disclosures occurring prior to the execution of any revocation.
4. If you request it, a copy of the information described in this form can be obtained at the front desk.
5. This form was completely filled in before I signed it and I acknowledge that all of my questions were answered to my satisfaction and that I fully understand this authorization form.
6. This authorization is valid as of the date I have signed below and shall remain valid until changed or revoked.

IV. Assignment of Benefits:
I hereby assign directly to Dr. Ricky Roach, all medical benefits, if any, otherwise payable to me for services rendered. I understand that all services rendered to me (or my dependents) are charged directly to me and I am personally responsible for payment of all charges whether or not paid by insurance. Patient or responsible party agrees to pay any and all costs of collection and/or attorney fees required to settle account. I authorize the use of this signature on all my insurance submissions. I hereby authorize the release of all information necessary to secure the payment of benefits. In order to insure proper follow-up and continuity of care, I agree that a copy of my medical records may be released to a designated referral provider and/or physician.

Signature of Parent/Guardian/Authorized Individual **Date**