



WELCOME TO THE MEDICAL FOOT CARE CENTER

Account# _____
DR. BRIAN MIDDLETON
Foot & Ankle Specialist
 211 REDMOND RD.
 ROME, GA 30165

1.) ABOUT YOU

TODAY'S DATE: _____

Mr. _____
 Mrs. _____
 Miss. _____
 LAST FIRST MR. MRS MS DR

I Prefer to be called: _____ MALE ___ FEMALE

Birthdate: ___/___/___ Age: ___ SS# _____

Home Address: _____
 _____ APT/CONDO#
 _____ CITY STATE ZIP

Email Address: _____
 ___ Single ___ Married ___ Divorced ___ Widowed ___ Separated

Home Phone Number _____

Cell Number _____

CONSENT TO RECEIVE TEXT MESSAGES OR EMAILS ABOUT APPOINTMENT REMINDERS AND OFFICE NEWSLETTERS:

_____ I consent to receive text messages from the practice at my cell phone or emails to receive appointment reminders. I understand that this request to receive text messages will apply to all future reminders unless I request a change in writing.

The cell phone number that I authorize to receive text messages is:

_____ The email that I authorize to receive text messages for appointment reminders and our informational office newsletters is:

_____ I decline in participating in this service.

2.) SPOUSE INFORMATION

Their name: _____

Employer: _____

WK#: _____ Ext _____ SS# _____

Birthdate: _____ DL# _____

3.) RESPONSIBLE PARTY

Please complete this section if someone other than the patient is Responsible for payment of services.

Person Responsible for Account: _____

WK# _____ Ext _____ HM# _____

Billing Address: _____

Relationship: _____ SS#: _____

Employer: _____

Employer's Address: _____

How long there? _____ Occupation: _____

Where & when are best times to reach you? _____

Who may we thank for referring you? _____

How did you learn about our office? _____

IN CASE OF AN EMERGENCY, PLEASE CONTACT:

NAME: _____

ADDRESS: _____

PHONE: _____

PHARMACY YOU CURRENTLY USE: (PLEASE WRITE AS MUCH INFO AS YOU KNOW) (e.g. West Rome Walmart)

NAME: _____

STREET/ROAD: _____

CITY: _____

I understand that I am financially responsible for all charges for services rendered and administered to me, including any balance after payment of possible insurance benefits. I further understand and agree that if I do not pay for all of the charges within 60 days of incurring them, I will pay interest on the outstanding balance at the rate of one and one-half percent (1-1/2%) per month. I further agree that I will pay reasonable attorney's fees and collection costs equal to fifteen percent (15%) of all principal and interest due and owing if legal action is required to collect any arrearages.

I also hereby authorize my insurance company (private or Medicare) to assign benefits, whether to me or on my behalf, directly to Dr. Brian Middleton for any services furnished by him or his staff. I also authorize the release of any medical information needed to determine these benefits or the benefits payable for related services. I further give Dr. Brian Middleton and his staff permission to examine and treat any condition that I have that in his opinion needs his services."

Patient
 Signature _____

Date _____

(If patient is under 18 years of age, this form must be signed by parent or guardian.)

***** IF YOU HAVE ANY QUESTIONS AT ANY TIME, PLEASE ASK US. WE ARE HAPPY TO HELP YOU. *****

PAST AND PRESENT MEDICAL PROBLEMS

IN THIS BOX OFFICE USE ONLY- Reviewed By: _____ Date: _____

Do you have or have you had any of the following? (*do not know)

Yes No *DNK				Yes No *DNK				Yes No *DNK			
Foot or Leg Injuries				Diabetes				Circulation of Arteries			
Foot or Leg Surgery				Heart Trouble				Hardening of Arteries			
Foot or Leg Cramps				Epilepsy/Stroke				Are you allergic to:			
Foot or Leg Numbness				Liver Disease				Novocaine			
Heel Pain				Kidney Disease				Penicillin			
Unequal Leg Length				Rheumatic Fever				Latex			
Weak Ankles				High Blood Pressure				Sulfa			
Bunions				Polio				Codeine			
Foot Skin Problems				Bursitis				Foods			
Toe Nail Problems				Stomach Ulcers				Other, If so describe			
Arch Pain				Asthma							
Anemia				Sexually Transmitted Diseases				Do you take blood thinners?			
Gout				HIV (+)				Are you pregnant?			
Arthritis				Bleeder				If yes, Due Date? _____			
Cancer				Blood Disease				Shoe Size _____ Weight _____			

IF YOU ANSWERED YES TO ANY OF THE ABOVE PLEASE INDICATE DATE CONDITION OCCURRED, TREATED OR NOT AND HAS THE CONDITION RESOVED.

MEDICATIONS
(IF AVAILABLE, PLEASE GIVE RECEPTIONIST A LIST TO MAKE A COPY)

HOSPITALIZATIONS OR SURGERY

Social History

<p>SMOKE</p> <p><input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>Number of Packs/Day _____</p> <p>How Long (Years) _____</p>	<p>ALCOHOL</p> <p><input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>How much? _____</p> <p>Type? _____</p>	<p>RECREATIONAL DRUGS</p> <p><input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>How much? _____</p> <p>Type? _____</p>
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TRAUMATIC ILLNESS: (Auto accidents, killings, gunshot, etc.)

CHILDHOOD ILLNESS: Measles() Mumps () Chicken pox () Polio () Other ()

FAMILY HISTORY:

Mother – (Alive/Dead) – Cause of Death _____

Father (Alive/Dead) – Cause of Death _____

Number of Siblings - _____

Number of brothers _____

Number of sisters _____

PATIENT NAME: _____ FAMILY PHYSICIAN _____ DATE LAST SEEN: _____

MEDICAL FOOT CARE CENTER

PATIENT NAME _____ DATE _____

PLEASE INDICATE ANY PERSONAL HISTORY BELOW, CIRCLE YES OR NO:

CONSTITUTIONAL SYMPTOMS

GOOD GENERAL HEALTH YES NO
RECENT WEIGHT CHANGE YES NO
FEVER YES NO
FATIGUE YES NO
HEADACHES YES NO

EYES

EYE DISEASE OR INJURY YES NO
WEAR GLASSES/CONTACTS YES NO
BLURRED OR DOUBLE VISION YES NO

EARS, NOSE/MOUTH/THROAT

HEARING LOSS OR RINGING YES NO
EARACHES OR DRAINAGE YES NO
CHRONIC SINUS PROBLEMS YES NO
RHINITIS YES NO
NOSE BLEEDS YES NO
BLEEDING GUMS YES NO
BAD BREATH OR BAD TASTE YES NO
SORE THROAT YES NO
VOICE CHANGE YES NO
SWOLLEN GLANDS IN NECK YES NO

CARDIOVASCULAR

HEART TROUBLE YES NO
CHEST PAIN YES NO
PALPATION YES NO
SHORTNESS OF BREATH YES NO
SWELLING OF FEET/ANKLES/ HANDS YES NO

RESPIRATORY

FREQUENT COUGHS YES NO
CHANGE IN BOWEL MOVEMENTS YES NO
VAUSEA OR VOMITTING YES NO
FREQUENT DIARRHEA YES NO
CONSTIPATION YES NO
RECTAL BLEEDING/BLOOD IN STOOL YES NO
ABDOMINAL PAIN YES NO

GENITOURINARY

FREQUENT URINATION YES NO
BURING/PAINFUL URINATION YES NO
BLOOD IN URINE YES NO
INCONTINENCE OR DRIBBLING YES NO
KIDNEY STONES YES NO
SEXUAL DIFFICULTY YES NO
MALE TESTICLE PAIN YES NO

FEMALE-PAIN WITH PERIODS YES NO
IRREGULAR PERIODS YES NO
OF PREGNANCIES _____
OF MISCARRIAGES _____
DATE OF LAST PAP SMEAR _____

MUSCULOSKELETAL

JOINT PAIN YES NO
JOINT STIFFNESS OR SWELLING YES NO
WEAKNESS OF MUSCLES OR JOINTS YES NO
MUSCLE PAIN OR CRAMPS YES NO
BACK PAIN YES NO
COLD EXTREMITIES YES NO
DIFFICULTY IN WALKING YES NO

INTEGUMENTARY (SKIN & BREASTS)

RASH OR ITCHING YES NO
CHANGE IN SKIN COLOR YES NO
CHANGE IN HAIR YES NO
CHANGE IN NAILS YES NO
VARICOSE VIENS YES NO
BREAST PAIN/LUMP OR DISCHARGE YES NO

NEUROLOGICAL

FREQUENT HEADACHES YES NO
LIGHT HEADED OR DIZZY YES NO
CONVULSIONS OR SEIZURES YES NO
NUMBNESS OR TINGLING YES NO
TREMORS YES NO
PARALYSIS YES NO
HEAD INJURY YES NO

PSYCHIATRIC

MEMORY LOSS OR CONFUSION YES NO
NERVOUSNESS YES NO
DEPRESSION YES NO
INSOMNIA YES NO

ENDOCRINE

GLANDULAR/HORMONE PROBLEM YES NO
EXCESSIVE THIRST OR URINATION YES NO
HEAT OR COLD INTOLERANCE YES NO
SKIN BECOMING DRYER YES NO
CHANGE IN HAT OR GLOVE SIZE YES NO

HEMATOLOGIC/LYMPHATIC

SLOW TO HEAL AFTER CUTS YES NO
BLEEDING OR BRUSING TENDENCY YES NO
ANEMIA YES NO
PHEBLITIS YES NO
PAST BLOOD TRANSFUSIONS YES NO
ENLARGED GLANDS YES NO

FOR OFFICE USE ONLY

Reviewed By:

Brian K. Middleton, D.P.M: _____

Date: _____

**MEDICAL FOOT CARE CENTER
ROME AMBULATORY SURGERY CENTER
211 REDMOND ROAD
ROME, GA 30165**

PATIENT BILL OF RIGHTS

1. THE PATIENT HAS THE RIGHT TO CONSIDERATE AND RESPECTFUL CARE.
2. THE PATIENT AS THE RIGHT TO OBTAIN FROM HIS PHYSICIAN COMPLETE, CURRENT INFORMATION CONCERNING HIS DIAGNOSIS, TREATMENT AND PROGNOSIS IN TERMS THE PATIENT CAN BE REASONABLE EXPECTED TO UNDERSTAND. WHEN IT IS NOT MEDICALLY ADVISABLE TO GIVE SUCH INFORMATION TO THE PATIENT, THE INFORMATION SHOULD BE MADE AVAILABLE TO AN APPROPRIATE PERSON ON HIS BEHALF. A PATIENT HAS THE RIGHT TO KNOW BY NAME THE PHYSICAIN RESPONSIBLE FOR COORDINATION HIS CARE.
3. THE PATIENT HAS THE RIGHT TO RECEIVE FROM HIS PHYSICIAN ANY INFORMATION NECESSARY TO GIVE INFORMED CONSENT PRIOR TO THE START OF ANY PROCEDURE AND/OR TREATMENT, AND THE MEDICALLY SIGNIFICANT RISK INVOLVED, AND THE PROBABLE DURATION OF INCAPACITATION. WHERE MEDICALLY SIGNIFICANT ALTERNATIVE FOR CARE OR TREATMENT EXIST, OR WHEN THE PATIENT REQUEST INFORMATION CONCERN MEDICAL ALTERNATIVES, THE PATIENT HAS THE RIGHT TO KNOW THE NAME OF THE PERSON RESPONSIBLE FOR THE PROCEDURE AND/OR TREATMENT.
4. THE PATIENT HAS THE RIGHT TO REFUSE TREATMENT TO THE EXTENT PERMITTED BY LAW, AND TO BE INFORMED OF THE MEDICAL CONSEQUENCES OF THE ACTION.
5. THE PATIENT HAS THE RIGHT TO EXPECT THAT ALL COMMUNICATIONS AND RECORDS PERTAINING TO HIS CARE SHOULD BE TREATED AS CONFIDENTIAL.
6. THE PATIENT HAS THE RIGHT TO EVERY CONSIDERATION OF HIS PRIVACY CONCERNING HIS OWN MEDICAL CARE PROGRAM. CASE DISCUSSION, CONSULTATION, EXAMINATION AND TEATMENT ARE CONFIDENTIAL AND SHOULD BE CONDUCTED DISCREETLY. THOSE NOT DIRECTLY INVOLVED IN HIS CARE MUST HAVE THE PERMISSION OF THE PATIENT TO BE PRESENT.
7. THE PATIENT HAS THE RIGHT TO EXPECT THAT WITHIN ITS CAPACITY AND OFFICE MUST MAKE REASONABLE REASPONSE TO THE REQUEST OF THE PATIENT FOR SERVICES. MEDICAL FACILITIES MUST PROVIDE EVALUATION, SERVICE, AND/OR REFERRAL AS INDICATED BY THE URGENCY OF THE CASE. WHEN MEDICALLY PERMISSIBLE, THE PATIENT MAY BE TRANSFERRED TO ANOTHER FACILITY ONLY AFTER RECEIVING COMPLETE INFORMATION AND EXPLANATION CONCERNING THE NEEDS FOR AND ALTERNATIVES TO A TRANSFER.
8. THE PATIENT HAS THE RIGHT TO OBTAIN INFORMATION AS TO THE EXISTENCE OF ANY PROFESSIONAL RELATIONSHIPS AMONG INDIVIDUALS, BY NAME, WHO ARE TREATING THEM.
9. THE PATIENT AS THE RIGHT TO EXPECT REASONABLE CONTINUITY OF CARE. HE HAS THE RIGHT TO KNOW IN ADVANCE WHAT APPOINTMENT TIMES AND PHYSICIANS ARE AVAILABLE.

SIGNATURE

**ACKNOWLEDGMENT OF RECEIPT
OF
PRIVACY PRACTICES**

I ACKNOWLEDGE THAT I WAS PROVIDED A COPY OF THE NOTICE OF PRIVACY PRACTICES AND THAT I HAVE READ (OR HAVE HAD THE OPPORTUNITY TO READ IF I SO CHOOSE) AND UNDERSTAND THE NOTICE.

SIGNATURE

DATE

PATIENT NAME (PLEASE PRINT)

PARENT OR AUTHORIZED REPRESENTATIVE (IF APPLICABLE)

I GIVE MY PERMISSION FOR DR. MIDDLETON OR HIS STAFF TO DISCUSS MY MEDICAL INFORMATION WITH THE FOLLOWING:

NAME

RELATIONSHIP

NAME

RELATIONSHIP