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.

The practice does not charge for this service, but standard text messaging rates may apply as provided in your wireless plan.

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. ******

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

SMOKE
❑ YES ❑ NO
Number of Packs/Day_____
How Long (Years)_____

ALCOHOL
❑ YES ❑ NO
How much?_____
Type?_____

RECREATIONAL DRUGS
❑ YES ❑ NO
How much?_____
Type?_____

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 VISON	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
NAUSEA 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 DIFFICULITY	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
DIFFICULITY 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 SURGICAL CENTER, P.C.
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 COMUNICATIONS 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