Chattanooga Foot Specialists, PLLC
Lisa Wamack, DPM

First Name_____**M.I.**_____**Last Name**_____
Address_____**Apt.**_____
City_____**State**_____**Zip Code**_____
Home Phone_____**Cell** _____**Wk**_____
Birthdate_____**Age**_____**Martial Status**_____
Sex _____ **Race** _____ **Language** _____
Social Security #_____ **Ethnicity: Non Hispanic or Hispanic**
Employer_____**Occupation**_____
Email Address _____

INSURANCE INFORMATION

Primary Insurance_____ **ID #**_____
Group#_____**Referral Required**_____
Cardholder's Name_____**Relationship to Cardholder**_____
Cardholder's SSN#_____**Cardholder's Birthdate**_____

Secondary Insurance_____ **ID #**_____
Group # _____ Cardholder's Name _____
Cardholder's SSN#_____**Cardholder's Birthdate** _____

Foot Problem_____

Primary Care Physician(required by Medicare)_____
How did you hear about us?_____

Emergency Contact

Name_____**Relationship**_____
Home Phone_____ **Cell**_____**Wk**_____

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Name_____Date_____

Circle Yes or No

Y or N Anemia
Y or N Arthritis: Osteo / Rheumatoid
Y or N Asthma
Y or N Bowel Problems
Y or N Cancer - Type _____
Y or N Circulation
Y or N Diabetes How long?_____
Y or N Heart Attack-When_____
Y or N Heart Problems-What_____
Y or N Hepatitis – Type_____
Y or N High Blood Pressure
Y or N HIV/AIDS
Y or N Kidney Problems – Dialysis
Y or N Liver Problems
Y or N Lung Disease
Y or N Phlebitis / Blood clots
Y or N Reflux
Y or N Stomach Ulcer
Y or N Stroke-When_____

Are you allergic to anything? medications? Y or N
If yes, please name_____
Do you take any medications? Y or N
If yes, please list or provide a list_____
_____
Have you ever had major surgery? Y or N
If yes, what type and when_____
_____
Are you disabled? Y or N Reason for disability_____
Do you smoke? Y or N How much?_____ How long?_____
Former smoker? Y or N
Family medical history: <u>Please list any major illness and if living or deceased.</u>
Mother_____ Father_____

Sister _____ Brother_____

PHARMACY_____
Address/Zip Code or Phone_____

Chattanooga Foot Specialists

Persons Authorized to Receive Health Information –

_____ _____

Name of Person – relation/organization **Name of Person – relation/organization**

Use and Disclosure of Information:

_____ I authorize the person(s) listed above to receive all healthcare information about appointments, treatments, and/or other information pertinent to my health care and/or payment for my health care provided at the office of Chattanooga Foot Specialists.

_____I do NOT authorize the following information to be disclosed to any other parties except me as the patient (please specify):

How would you like to be contacted regarding appointments, treatment and/or other information pertinent to healthcare and/or payment for your health care provided by this office? (Check all that apply)

_____home phone _____work phone _____cell phone

May we leave messages if you have an answering machine or voice mail? Y or N

_____ I have received a copy of the Privacy Policy and the Financial and Consent for Treatment Policy from Chattanooga Foot Specialists.

_____ _____

Name of Patient (PRINT) **Signature of Patient**

_____ _____

Signature of Patient Representative/Relationship **Date**

Financial and Consent for Treatment

I consent for treatment of the above named patient. I authorize the release of all medical records to the referring and primary care physicians and to my insurance company. I allow fax transmittal of my medical records if necessary. I acknowledge full responsibility for the cost of services rendered by Dr. Wamack. I understand that payment of charges incurred is due at the time of service unless other definite financial arrangements have been made prior to treatment. I agree to pay all reasonable attorney fees and collection costs in the event of default of my payment. I further authorize and request that insurance payments be made directly to Dr. Wamack. I have read and fully understand the above consent for treatment, financial responsibility, release of medical information and insurance authorization.