DATE:_____

Dr. Stephan J. LaPointe
D.P.M.,PhD.

PATIENT INFO:

NAME: FIRST_____MI____LAST_____

ADDRESS_____

CITY_____STATE_____ ZIP_____

SS# _____DOB ____/____/____ AGE: _____SEX: M__F__

PHONE ( ) _____ CELL PHONE ( ) _____EXT_____

E-MAIL_____EMPLOYER _____

MARITAL STATUS: SINGLE_____MARRIED_____DIVORCED_____OTHER____

SPOUSE'S NAME: _____SS# _____DOB ____/____/____

SPOUSE'S EMPLOYER _____ WORK NUMBER_____

RESPONSIBLE PARTY (IF OTHER THAN PATIENT)

NAME: _____RELATIONSHIP _____

DOB: _____/_____/_____ SS# _____

ADDRESS:_____CITY_____STATE_____

PHONE: ( )_____ EMPLOYER:_____

WORK PHONE# _____ EXT_____

EMERGENCY CONTACT NOT LIVING WITH YOU:

NAME; _____

RELATIONSHIP:_____

PHONE:_____

Georgia Foot and Ankle Specialists
409 West 10th St.
Rome, GA 30165

Consent for Treatment

I hereby give Dr. LaPointe and/or his associate's permission to examine and treat my foot or leg problems. If insurance is filed, I authorize payment to be made to me, or the doctor. I further authorize the release of any medical information necessary to process claims. I accept full responsibility for any charges on this account. I understand that should I neglect to pay my bill and allow my account to be turned over to a collection agency, a collection fee of up to 40% of the balance due will be added back to my account. I understand it is my responsibility to understand my insurance benefits and that this office is happy to provide care within my insurance companies guidelines as long as I make them aware of these guidelines. If I do not properly inform the office of special requirements, and services/supplies are ordered that are not covered, I will be billed for the charge. With cooperation between this office and myself, I should be able to receive all of the benefits offered, while being able to concentrate on caring for my medical needs. I have read and understand the office policy stated above and agree to accept responsibility as described.

Patient Name (print please) _____

Patient Signature _____
Date _____

Guardian or legal representative _____
Date_____

Relationship to patient _____

Primary Insurance _____

Secondary Insurance _____

GEORGIA foot & ankle SPECIALISTS

ACKNOWLEDGEMENT 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.

Contact Preferences:

Okay to leave message on your phone/cell with:

___ Patient only
___ Patient and/or spouse
___ anyone answering the phone

_____ _____

Patient Name (please print) Date

_____

Parent or Authorized Representative (if applicable)

_____

Signature

SUMMARY OF NOTICE OF PRIVACY PRACTICES

Uses and Disclosures of Health Information: We will use and disclose your health information in order to treat you or to assist other health care providers in treating you. We will also use and disclose your health information in order to obtain payment for our services or to allow insurance companies to process insurance claims for services rendered to you by us or other health care providers. Finally, we may disclose your health information for certain limited operational activities such as quality assessment, licensing, accreditation and training of students.

Uses and Disclosures Based on Your Authorization: Except as stated in more detail in the Notice of Privacy Practices, we will not use or disclose your health information without your written authorization.

Uses and Disclosures Not Requiring Your Authorization:
In the following circumstances, we may disclose your health information without your written authorization:

- To family members or close friends who are involved in your health care;
- For certain limited research purposes;
- For purposes of public health and safety;
- To Government agencies for purposes of their audits, investigations and other oversight activities;
- To government authorities to prevent child abuse or domestic violence;
- Tot the FDA to report product defects or incidents;
- To law enforcement authorities to protect public safety or to assist in apprehending criminal offenders;
- When required by court orders, search warrants, subpoenas and as otherwise required by law.

Patient Rights: As our patient, you have the following rights:

- To have access to and/or a copy of you health information;
- To receive an accounting of certain disclosures we have made of your health information;
- To request restrictions as to how your health information is used or disclosed;
- To request that we communicate with you in confidence;
- To request that we amend your health information;
- To receive notice of our privacy practices.

If you have question, concern or complain regarding our privacy practices, please inform our office manager.

Welcome to Georgia Foot & Ankle Specialist

1100 Martha Berry Blvd, Rome, GA 30165
706-232-2888 O - 877-795-8359 F
Dr. Stephan LaPointe D.P.M./Ph.D.

Name:_____ DOB:_____/_____/_____

Describe your primary foot or ankle concern:

Brief description of the concern:

right foot ____left foot ____right ankle ____left ankle ____right leg ____left leg toes

If you have pain, describe the nature of the pain:

dull ___ache ___sharp ___electrical ___burning ___numbing ___tingling
Other: _____

How often does it hurt of affect you?

at all times ____daily ____weekly ____worse at night ___worse in morning
Other:_____

How long have you had pain (enter number)? #: _____days #:_____ weeks #:_____months #:_____years

How has the issue progressed? ____about the same ____getting better ____getting worse

Describe any treatment for this problem:_____

Does anything make it worse?_____

Does anything make if better?_____

Are there any hobbies or activities that are restricted?_____

Personal History- Please check if **you** have any of the following conditions:

Arthritis _____
Blood Clot (DVT)_____
Back Pain _____
Cancer _____
Circulation Problems _____
COPD_____
Diabetes _____
Depression _____
Gout _____
Heart Disease _____
High/Low Blood Pressure_____
Kidney Disease _____
Leg Pain/ Swelling _____
Osteoporosis _____
Stroke _____
Ulcer _____
Other :_____

Social History:

Alcohol: ____None ____Rare ____Socially ____1-2 drinks per day ____More than 2 drinks per day

Smoker/Tobacco: ____Yes ____No ____Quit Number of packs per _____day for _____ years

Occupation:

Surgical History: Foot & Ankle & Leg Surgery- Please check if **you** had any of the following surgeries:

Achilles Lengthening _____
Amputation of foot _____
Amputation of toe _____
Amputation of leg _____
Ankle fracture repair _____
Ankle scope_____
Bypass of leg arteries _____

Fibroma removal ____

Ganglion removal _____
Hammertoe Repair _____
Heel Spur removal _____
Heel plantar fascia _____
Neuroma Repair _____
Toenail removal _____
Vein stripping _____

Wart removal _____

Family History- Please check if **blood relatives** have any of the of the following conditions:

Blood Clots	__Mother	__Father
Cancer	__Mother	__Father
Diabetes	__Mother	__Father
Gout	__Mother	__Father
Heart Disease	__Mother	__Father
High Blood Pressure	__Mother	__Father
Kidney Disease	__Mother	__Father
Rheumatoid arthritis	__Mother	__Father
Stroke	__Mother	__Father

Are you a patient at a pain management clinic? _____Yes ____No

Pain Management Physician's Name _____

Immunizations: Date of last tetanus shot _____

Shoe Size:_____ Height:_____ Weight:_____

Referring Physician: _____

Primary Care Physician:_____

Vascular Physician:_____

Retained hardware (metal of any kind in your body): ____Yes ____No Type:

I am currently not taking any medication _____

Please List All The Medication You Take:
Medication
Dose
Times Per
Day
Purpose

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Please List All Medications You Are Allergic To:
I have NO known allergies _____
Medication
Reaction It Caused

_____

_____

_____

_____

Pharmacy _____ Telephone # _____