Dr. Sarah Benjamin, DPM New Patient Paperwork

PLEASE DO NOT USE CREAM OR LOTION ON THE DAY OF YOUR APPOINTMENT

Today's Date:_____

Patient Name:_____ Date of Birth:_____

Address:_____ City:_____State:_____ Zip:_____

Patient's Social Security #:_____

Home Phone:_____ Cell Phone:_____ Work Phone:_____

Email (optional):_____

May we leave a detailed message at all phone numbers/email? Yes No (circle)

Parent/Legal Guardian (If patient is under age 18):_____Tel:_____

Primary Care Physician:_____ Tel:_____ Last Visit:_____

*My preferred Pharmacy Name:*_____ *Tel:*_____

How did you hear about us:_____

PRIMARY INSURANCE

Insurance Name:_____Effective Date:_____

Policy Holder's Name:_____Policy Holder's Date of Birth:_____

Patient relationship to Primary Policy Holder: spouse child other:_____

Primary Policy Holder's Address:_____

SECONDARY or SUPPLIMENTAL INSURANCE (circle)

Insurance Name:_____Effective Date:_____

Policy Holder's Name:_____Policy Holder's Date of Birth:_____

Patient relationship to Primary Policy Holder: spouse child other:_____

Primary Policy Holder's Address:_____

After insurance claims have been processed, who is responsible for any remaining charges?

Name:_____Relationship:_____

Address:_____ Tel:_____

Due to HIPAA regulation laws, is there a person(s) who may access your medical records, pick-up paperwork, scripts, etcetera, or someone we may share your medical record information with at anytime (also in the unlikely event of an emergency)?

Yes No (circle)

Name:_____ Relationship:_____ Tel:_____

Name:_____ Relationship:_____ Tel:_____

ASSIGNMENT & RELEASE

I acknowledge that my account and knowledge of my insurance benefits are ultimately my responsibility and that Dr. Sarah Benjamin, DPM cannot guarantee payment, benefits, or coverage by my insurance company. I authorize the office of Dr. Sarah Benjamin, DPM to release medical information for treatment, payment, or daily operations. I authorize my insurance benefits to be paid directly to Dr. Sarah Benjamin, DPM, realizing that I am responsible for all non-covered services. I will inform the office of Dr. Sarah Benjamin, DPM immediately of any insurance or personal information changes. To the best of my knowledge, I have answered the questions on this form accurately. I understand that providing incorrect information can be dangerous to my health. I understand that it is my responsibility to inform the doctor and the office staff of any changes in my medical status. I voluntarily consent to examination and treatment for myself or the above mentioned dependent patient.

_____

Print Name of Patient/Parent/Legal Guardian

_____ _____

Signature of Patient/Parent/Legal Guardian **Date**

Dr. Sarah Benjamin, DPM

New Patient Paperwork

PATIENT NAME:_____

PATIENT HISTORY

Height:_____ Weight:_____ Shoe Size:_____ Shoe Width:_____

Please describe your podiatric difficulties:_____

_____

Date of last Tetanus Shot:_____

Have you ever had a blood transfusion?_____

If you are female, is there any chance you might be pregnant? Yes No (circle)

ALLERGIES

☐ Adhesives/tapes	☐ Mercurial	☐ Sulfa
☐ Antihistamines	☐ Merthiolates	☐ Tetanus, Antitoxin, Serum
☐ Aspirin	☐ Mycins or other antibiotics	☐ Latex/Latex Gloves
☐ Codeine	☐ Novocain	☐ _____
☐ Demerol	☐ Nylon/Plastics	☐_____
☐ Iodine	☐ Penicillin	☐ NO KNOWN ALLERGIES

MEDICATIONS

(prescriptions, over-the-counter medications, vitamins, and supplements)

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

PAST MEDICAL HISTORY

☐ Anemia	☐ Heart Disease	☐ Mumps
☐ Arthritis/Rheumatism	☐ Heart Murmur	☐ Osteoporosis
☐ Bleeding Disorder	☐ Hepatitis Type:____	☐ Peripheral Vascular Disease
☐ Blood Clots	☐ High Blood Pressure	☐ Polio
☐ Bowel Disease	☐ HIV/AIDS	☐ Rheumatic Fever
☐ Cancer	☐ Kidney Disease	☐ Rubella
☐ Depression	☐ Liver Disease	☐ Scarlet Fever
☐ Diabetes	☐ Low Blood Sugar	☐ Skin Disease
☐ Diphtheria	☐ Lung Disease	☐ Stomach Ulcers
☐ Epilepsy (seizures)	☐ Measles	☐ Stroke
☐ Frequent Infections	☐ Mental Illness	☐ Thyroid Disease
☐ Glaucoma	☐ Migraine Headaches	☐ Varicose Veins
☐ Gout	☐ Mitral Valve Prolapse	☐ Venereal Disease

☐ Other(s):_____

_____

_____

PATIENT NAME:_____

INJURIES

Injury:_____ Month/Year:_____
Injury:_____ Month/Year:_____
Injury:_____ Month/Year:_____
Injury:_____ Month/Year:_____

HOSPITALIZATIONS

Reason:_____ Month/Year:_____
Reason:_____ Month/Year:_____
Reason:_____ Month/Year:_____
Reason:_____ Month/Year:_____

SURGICAL HISTORY

Surgery:_____ Month/Year:_____
Surgery:_____ Month/Year:_____
Surgery:_____ Month/Year:_____
Surgery:_____ Month/Year:_____

SOCIAL HISTORY

Smoking: Yes No (circle) If yes, amount:_____ How long:_____ Type:_____
Alcohol: Yes No (circle) If yes, amount:_____ How long:_____ Type:_____
Caffeine: Yes No (circle) If yes, amount:_____ How long:_____ Type:_____

FAMILY HISTORY

(Please check all boxes that apply)

DIAGNOSIS	MOTHER	FATHER	MOTHER'S PARENTS	FATHER'S PARENTS	SIBLINGS	CHILDREN
Bleeding Disorders						
Cancer						
Epilepsy/ Convulsions						
Glaucoma						
Heart Disease						
High Blood Pressure						
Kidney Disease						
Mental Illness						
Osteoporosis						
Stroke						
Thyroid Disease						

PATIENT NAME:_____

ACKNOWLEDGEMENT OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW DR. SARAH BENJMAMIN, DPM MAY USE AND DISCLOSE YOUR HEALTHCARE INFORMATION AND HOW YOU CAN OBTAIN ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY

DR. SARAH BENJAMIN, DPM is required by law to maintain the privacy of your protected health information. This information consists of all records related to your health, including demographic information, either created by Dr. Sarah Benjamin, DPM or received by Dr. Sarah Benjamin, DPM from other healthcare providers.

We are required to provide you with notice of our legal duties and privacy practices with respect to your protected health information. These legal duties and privacy practices are described in this Notice. Dr. Sarah Benjamin, DPM will abide by the terms of this Notice, or the Notice currently in effect at the time of the use or disclosure of your protected health information.

Dr. Sarah Benjamin, DPM reserves the right to change the terms of this Notice and to make any new provisions effective for all protected health information that we maintain. Patients will be provided a copy of any revised Notices upon request. An individual may obtain a copy of the current Notice from our office at any time.

Uses and Disclosures of Your Protected Health Information not Requiring Your Consent
Dr. Sarah Benjamin, DPM may use and disclose your protected health information, without your written consent or authorization, for certain treatment, payment and healthcare operations. There are certain restrictions on uses and disclosures of treatment records, which include registration and all other records concerning individuals who are receiving, or who at any time have received services for mental illness, developmental disabilities, alcoholism, or drug dependence. There are also restrictions on disclosing HIV test results. **Please see full Privacy Practices for details and a list disclosure examples.**

Dr. Sarah Benjamin, DPM will not make any other use or disclosure of your protected health information without your written authorization. You may revoke such authorization at any time, except to the extent that Dr. Sarah Benjamin, DPM has taken action in reliance thereon. Any revocation must be in writing.

You are permitted to request that restrictions be placed on certain uses or disclosures of your protected health information by Dr. Sarah Benjamin, DPM to carry out treatment, payment, or healthcare operations. You must request such a restriction in writing. We are not required to agree to your request, but if we do agree, we must adhere to the restriction, except when your protected health information is needed in an emergency treatment situation. In this event, information may be disclosed only to healthcare providers treating you. Also, a restriction would not apply when we are required by law to disclose certain healthcare information.

You have the right to review and/or obtain a copy of your healthcare records, with the exception of psychotherapy notes, or information compiled for use (or in anticipation for use) in a civil, criminal, or administrative action or proceeding. Dr. Sarah Benjamin, DPM may deny an access under other

circumstances, in which case you have the right to have such a denial reviewed. We may charge a reasonable fee for copying your records.

You may request that Dr. Sarah Benjamin, DPM send protected health information, including billing information, to you by alternative means or to alternative locations. You may also request that Dr. Sarah Benjamin, DPM not send information to a particular address or location or contact you at a specific location, perhaps your place of employment. This request must be submitted in writing. We will accommodate reasonable requests by you.

You have the right to request that Dr. Sarah Benjamin, DPM amend portions of your healthcare records, as long as such information is maintained by us. You must submit this request in writing, and under certain circumstances the request may be denied.

You may request to receive an accounting of the disclosures of your protected health information made by Dr. Sarah Benjamin, DPM for the six years prior to the date of the request, beginning with disclosures made after April 14, 2003. We are not required, however, to record disclosures we make pursuant to a signed consent or authorization.

You may request and receive a paper copy of this Notice, if you had previously received or agreed to receive the Notice electronically.

Any person or patient may file a complaint with Dr. Sarah Benjamin, DPM and/or the Secretary of Health and Human Services if they believe their privacy rights have been violated. To file a complaint with Dr. Sarah Benjamin, DPM, please contact the Privacy Officer at the following:

Privacy Officer – Laura Ray, MHA
Dr. Sarah Benjamin, DPM,
7780 S. Broadway, Suite 255
Littleton, CO 80122
(303) 470-1830

It is the policy of Dr. Sarah Benjamin, DPM that no retaliatory action will be made against any individual who submits or conveys a complaint of suspected or actual non-compliance or violation of the privacy standards.

This Notice of Privacy Practices is effective April 14th 2003

I acknowledge that I have read, been provided a complete copy, and that I understand the Notice of Privacy Practices.

_____

Print Name of Patient/Parent/Legal Guardian

_____ _____

Signature of Patient/Parent/Legal Guardian **Date**