S. J. FISHER, DPM
FOOT AND ANKLE SPECIALIST, PA

PATIENT:		DOB:	MEDICAL RECORD #:
DATE:	TIME:	LOCATION:	

CONSENT FOR TREATMENT: By this document, I do hereby request and authorize S. J. Fisher & Associates, its medical practices and providers including physicians, technicians, nurses, and other qualified personnel to perform evaluation and treatment services and procedures as may be necessary in accordance with the judgment of the attending medical practitioner(s). I acknowledge that no guarantee can be made by anyone concerning the results of treatments, examinations or procedures.

PRIVACY NOTICE: I acknowledge receipt of the Health Information Privacy Notice for S. J. Fisher & Associates.

INSURANCE AUTHORIZATION AND ASSIGNMENT: I request that payment of authorized medical benefits is made on my behalf directly to the S. J. Fisher & Associates provider of service(s) furnished to me. I authorize S. J. Fisher & Associates to release any medical information to my health insurance carrier and/or its legitimate agents that is necessary to process related health insurance claims and/or to verify plan benefits in accordance with HIPAA health information standards. I authorize payment of service(s), otherwise payable to me under the terms of my private, group employer's or group health insurance plan, directly to S. J. Fisher & Associates. I hereby authorize that photocopies of this form to be valid as the original.

PAYMENT GUARANTEE: I do hereby guarantee payment of all fees and charges related to all services and durable goods provided to me through S. J. Fisher & Associates medical practices and providers from my first date of examination or treatment. I agree to make full payment immediately upon receipt of an S. J. Fisher & Associates billing statement whether it is an interim or final bill. In the event that I fail to make full payment or fail to comply with other payment arrangements made with S. J. Fisher & Associates approval, I understand that appropriate collection measures may be initiated.

ELECTRONIC HEALTH RECORD: Healthcare providers require access to patient medical information whenever or wherever a patient presents for care to assure safety, quality and to coordinate patient care across the provider network, avoiding duplication of services. Confidentiality of records including those reflecting treatment for behavioral health issues, HIV/AIDS or drug or alcohol problems is maintained per relevant governmental and regulatory standards. Patient care summaries are automatically sent to designated S. J. Fisher & Associates and other community primary care/family/referring physicians, as well as to physicians who are consulted by the attending physician for coordination of care. S. J. Fisher & Associates and/or the attending physician can furnish and release to federal and state healthcare oversight agencies, or upon written request, to all insurance companies or their representatives any information with respect to treatment of the patient herein named including copies of the medical record.

ELECTRONIC PRESCRIBING: I understand that S. J. Fisher & Associates medical practices and offices may use an electronic prescription system which allows prescriptions and related information to be electronically sent between my S. J. Fisher & Associates providers and my pharmacy. I have been informed and understand that S. J. Fisher & Associates providers using the electronic prescribing system will be able to see information about medications I am already taking, including those prescribed by other providers. I give my consent to my S. J. Fisher & Associates providers to see this health information.

RELEASE OF RESPONSIBILITY FOR PERSONAL VALUABLES: I have been made aware and understand that all S. J. Fisher & Associates medical practices and offices provide no facilities for safekeeping of valuables. I do hereby release S. J. Fisher & Associates from any responsibility due to loss or damage of any valuables that I, or anyone accompanying me, may bring to an S. J. Fisher & Associates medical practice, office or facility.

I, or my legal representative, certify that I have read this document, that it has been fully explained to me and that I understand its contents, and hereby agree to all terms and conditions set forth above and acknowledge the receipt of a copy if requested

Signature of Patient or Parent/Legal Guardian/Authorized Representative

Relationship to Patient if Applicable

Printed Name

Date of Signing

01/2022 version

NEW PATIENT FORM S. J. FISHER, DPM FOOT AND ANKLE SPECIALIST, PA **PLEASE PRINT**

Date of Birth:___/___/___Last Name:_____First Name:_____MI:_____
Address:_____City:_____State:_____Zip:_____

Home #:_____Cell #: _____Work #: _____

Emergency Contact:_____Phone: _____Relationship:_____

E-Mail: _____

Family Physician:_____Phone Number: _____

Fax Number: _____

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced

Employer:_____Employer Address:_____

__FULL TIME___PART TIME___NOT EMPLOYED___SELF-EMPOYED___RETIRED___ACTIVE MILITARY DUTY___STUDENT

Pharmacy:_____Pharmacy Phone Number: _____

Pharmacy Address:

HOW DID YOU HEAR ABOUT US: **Doctor Referral** ☐ **Insurance** ☐ **Friend/Family** ☐ **Internet/Google** ☐

Referred by:_____Other:_____

ASSIGNMENT OF INSURANCE BENEFITS

The undersigned hereby authorizes the release of any information relating to all claims for benefits submitted on behalf of myself and/or my dependents. I further expressly agree and acknowledge that my signature on this document authorizes my physician to submit claims for benefits and services rendered, without obtaining my signature on each and every claim to be submitted for myself and/or my dependents. I will be bound by this signature as though the undersigned had personally signed the particular claim.

I,_____, herby authorize_____to pay and hereby assign directly to ***SJ FISHER FOOT & ANKLE SPECIALIST*** *all benefits. I further acknowledge that any insurance benefits, when received by and paid to YOUR PRACTICE NAME will be credited to my account in accordance with the above said assignment.*

Agreed & Authorized:_____**Date**: _____

Social History

Do or Did you smoke cigarettes?	☐Yes	☐No	If Yes, packs per day?_____	Stop date: _____
Drink alcohol regularly?	☐Yes	☐No	Do you exercise regularly?	☐Yes ☐No
Allergies to any medication?	☐Yes	☐No	If Yes, which medications?	_____
Do you vape	☐ Yes	☐No		
Do you use drugs	☐Yes	☐No		

Please list ALL medications you are currently taking: _____

_____

_____

_____

_____

_____

SJ FISHER FOOT & ANKLE SPECIALIST - NEW PATIENT FORM **PLEASE PRINT**

Previous Surgery/Hospitalizations_____

_____

FAMILY HISTORY (check if anyone in your family has had or had the following)

	MOTHER	FATHER	SILBINGS	CHILDREN	OTHER RELATIVE
CANCER					
DIABETES					
HEART DISEASE					
ARTHRITIS					
OSTEOPOROSIS					
AGE (IF LIVING)					

SYSTEMIC REVIEW (DO YOU NOW HAVE OR EVER HAD THE FOLLOWING)

	YES	NO
Chronic Headaches/Migraines		
Dizziness		
Chronic Back/ Neck Pain		
Arthritis		
Color changes in hands/ Feet		
Skin rash		
Impaired Hearing		
Psoriasis		
Stomach Ulcer		
Anemia		
Asthma		
Depression		
Thyroid Disorder		
Anxiety		
Osteoporosis		
Heart disease		
Tuberculosis Exposure		
HIV		
Numbness/Tingling of hand/Feet		
Swelling of____Feet_____Ankles		
Joint Pains/Swelling		
High Cholesterol		
Heart attack/ stroke		
Cancer		
High Blood Pressure		
Diabetes		
Kidney Disease/Stones		
Pancreatitis		
Diverticulitis		
Phlebitis		
Heart Murmur/ Palpitations		

Date of Most Recent Medical Exam: _____

Reason for office visit today: _____

_____

_____

_____