FOOT SPECIALISTS
OF SOUTH MISSISSIPPI

DR. CHARLES CAPLIS
PHONE: 228-818-2801
FAX: 228-818-2803

PATIENT INFORMATION

First Name____________________Middle Initial___Last Name___________________Suffix ____

Date of Birth_____________ Gender ☐ M ☐ F Social Security # ----------------- _______

Address___________________________City________________State_____Zip Code ___________

Phone Number (____)_______________ Cell Phone (____)_______________

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Other

EMPLOYMENT INFORMATION

Employer_____________________________ Job Title ____________________________

Address______________________________City____________State______Zip Code___________

Phone Number (___) _______________

Employment Status: ☐ Full Time ☐ Part Time ☐ Retired ☐ Self Employed ☐ Unemployed

EMERGENCY CONTACT

Name_____________________Relationship to Patient:_______Phone Number(____)_________

INSURANCE INFORMATION

Primary Policy:

Insurance Carrier_____________________

ID/Policy Number_____________________

Name of Policy Holder_____________________

Date of Birth of Policy Holder_________________

Relationship to Patient_____________________

Secondary Policy:

Insurance Carrier _____________________

ID/Policy Number _____________________

Name of Policy Holder _____________________

Date of Birth of Policy Holder________________

Relationship to Patient ______________________

VISIT REASON

Why are you seeing the doctor today? ____

Is there pain associated with this condition? ☐ Yes ☐ No

What causes or aggravates the pain? ____

What works best to relieve the pain? ____

Any additional factors you would like to mention? __________________________________

Whom may we thank for your referral today? ____________________________________

Primary Care Physician (**PCP**):___________________**Date of Last PCP Visit**: _________________

Pharmacy Information: ________________________________

ALLERGIES

1. Please indicate all allergies to medications:

☐ No Known Drug Allergies

Medication	Reaction	Medication	Reaction

Other Allergies: ☐ Adhesives ☐ Band Aids/Tape ☐ Gloves ☐ Latex

2. Do you have any complications due to Anesthesia? ☐ Yes ☐ No Describe ___________________

MEDICATIONS

Please include prescriptions, over the counter, vitamins and supplements.

– **You may also submit a <u>current medication list</u>,** for your convenience.

Medication	**Dosage**	**Frequency**	**Medication**	**Dosage**	**Frequency**

PAST MEDICAL HISTORY

Please CHECK any conditions that currently apply OR that you have experienced in the past:

Constitutional/General

- ☐ Cancer Type:_______
- ☐ Elevated Temperature
- ☐ Night Sweats

Cardiovascular

- ☐ Angina
- ☐ Blood Clots/DVT
- ☐ Easy Bruising/Bleeding
- ☐ Heart Attack
- ☐ Hypertension
- ☐ Irregular Heart Beat
- ☐ Poor Circulation
- ☐ Rheumatic Fever
- ☐ Valve Problems

Respiratory

- ☐ Asthma
- ☐ Chronic Cough
- ☐ COPD
- ☐ Emphysema
- ☐ Shortness of Breath
- ☐ Sleep Apnea/CPAP

Infectious Disease

- ☐ HIV /AIDS
- ☐ STDs
- ☐ Tuberculosis/TB

Gastrointestinal

- ☐ Acid Reflux/GERD
- ☐ Gall Bladder
- ☐ Hiatal Hernia
- ☐ IBS
- ☐ Stomach/Bowel Problems
- ☐ Ulcers

Genito-Urinary

- ☐ Bladder or Kidney Stones
- ☐ Infection
- ☐ Kidney Failure
  - ☐ Dialysis
- ☐ Prostate Disease

Endocrine

- ☐ Heat or Cold Intolerance
- ☐ Diabetes
- ☐ Hyperthyroid
- ☐ Hypothyroid

Hematologic Disease

- ☐ Anemia Type:_______
- ☐ Sickle Cell

Liver

- ☐ Cirrhosis
- ☐ Hepatitis
- ☐ Jaundice

Musculoskeletal

- ☐ Double/Blurred Vision
- ☐ Glaucoma
- ☐ Hearing Deficit/Loss
  - ☐ Hearing Aid
- ☐ Macular Degeneration
- ☐ Vision Changes
  - ☐ Contacts/Glasses

Nervous System

- ☐ Anxiety
- ☐ Depression
- ☐ Convulsions/Epilepsy
- ☐ Fainting
- ☐ Memory Loss
- ☐ Migraines
- ☐ Muscle Weakness
- ☐ Muscular Dystrophy
- ☐ Muscular Sclerosis
- ☐ Stroke
- ☐ Neuropathy
- ☐ Parkinson's Disease
- ☐ **Other**: ____________

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________________ ☐

____

SOCIAL HISTORY

1. Do you currently smoke or chew tobacco? ☐ YES ☐ NO
   How many packs/cans per day?______ How many years? _______
   If NO, have you in the past? ☐ YES ☐ NO For how many years?________
2. Do you drink alcohol? ☐ YES ☐ NO How many glasses/drinks per day? ________
3. Do you drink caffeine? ☐ YES ☐ NO How many cups/drinks per day? _________
4. Do you use any illicit drugs (i.e. marijuana, cocaine, heroin, etc.)? ☐ YES ☐ NO
   If yes, which drugs? ______________
   If no, have you in the past? ☐ YES ☐ NO Which drugs? __________________

SURGICAL HISTORY:

Please List Any Surgeries **AND** Year:

____

____

____

____

____

FAMILY HEALTH HISTORY:

Mother:______________________________________

Father:______________________________________

Siblings:_____________________________________

Children:_____________________________________

Maternal Grandparents:

Paternal Grandparents:___________________________

PATIENT HIPAA ACKNOWLEDGEMENT AND DESIGNATION DISCLOSURE FORM

I. **Acknowledgement of Practice's *Notice of Privacy Practices:***
By subscribing my name below, I acknowledge that I was provided a copy of the Notice of Privacy Practices (NPP), and that I have read (or had the opportunity to read if I so chose) and understand the Notice of Privacy Practices (NPP) and agree to it's terms.

Name of Patient	Date of Birth	Signature of Patient/Representative	Date

II. Designation of Certain Relatives, Close Friends and/or Caregivers as my Personal Representative:
I agree that the practice may disclose parts of my health information to a Personal Representative of my choosing, since such person is involved with my healthcare and/or payment relating to my healthcare. In that case, the Physician/Practice will disclose only information that is directly relevant to the person's involvement with my healthcare or payment relating to my healthcare.

Print Name:________________________________ DOB or Other Identifier: _______________

Print Name:________________________________ DOB of Other Identifier: ________________

III. Request to Receive Confidential Communications by Alternative Means:
As provided by Privacy Rule Section 164.522(b), I hereby request that the Practice make all communications to me as I have listed below:

Home Telephone Number:

☐ Okay to leave a message with detailed information **- OR -** ☐ Leave message with call back number only

Work Telephone Number:

☐ Okay to leave message with detailed information - **OR** - ☐ Leave message with call back number only

Cell Telephone Number:

☐ Okay to leave message with detailed information - **OR** - ☐ Leave message with call back number only

EMAIL:________________________________ ☐ Okay to email address Practice has on file

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1. The above authorizations are voluntary and I may refuse to their terms without affecting any of my rights to receive healthcare at the Practice
2. These authorizations may be revoked at any time by notifying the Practice in writing at the Practice's mailing address marked to the attention of "HIPAA Compliance Officer."
3. The revocation of this authorization will not have any effect on disclosures occurring prior to the execution of any recovation.
4. If you request it, a copy of the information described in this form can be obtained at the front desk.
5. This form was completely filled in before I signed it and I acknowledge that all of my questions were answered to my satisfaction and that I fully understand this authorization form.
6. This authorization is valid as of the date I have signed below and shall remain valid until changed or revoked.

IV. Assignment of Benefits:
I hereby assign directly to Dr. Charles Caplis, all medical benefits, if any, otherwise payable to me for services rendered. I understand that all services rendered to me (or my dependents) are charged directly to me and I am personally responsible for payment of all charges whether or not paid by insurance. Patient or responsible party agrees to pay any and all costs of collection and/or attorney fees required to settle account. I authorize the use of this signature on all my insurance submissions. I hereby authorize the release of all information necessary to secure the payment of benefits. In order to insure proper follow-up and continuity of care, I agree that a copy of my medical records may be released to a designated referral provider and/or physician.

Signature of Patient OR Patient Representative	**Date**