Noah Foot and Ankle Center, PLLC
DEMOGRAPHICS & PRIMARY COMPLAINT

It is a requirement of the federal government that this information be collected on each new patient & updated yearly for existing patients. Thank you for your cooperation, Dr. Noah and Staff

Demographic Information:

Patient Name _____DOB _____ Sex: --
First Middle Last

Current Occupation: _____ Hours per shift on your feet: _____

Address _____City _____ State _____ Zip _____

Home Phone: _____ Cell Phone: _____ Preferred Phone: --

Email Address _____ Social Security Number: _____

Race: White / Native American / Asian / Black/African American / Native Hawaiian/Other Pacific Islander / Other

Ethnicity: -- Primary Language: --

Were you referred to our office? Yes / No If yes please tell us how: _____

Receive alerts, reminders, or messages through: --

****If you do not confirm either your text or email reminder, you will receive a reminder phone call the day before your scheduled appointment. ****

Emergency Contact Information:

Name _____Relation to Patient _____ Phone _____

Parent or Legal Guardian/Representative Information (if applicable)

Name _____Relationship to Patient _____ Phone _____

Address _____ City _____ State _____ Zip _____

Insurance Information:

We will take physical copies of your insurance cards to keep on file.

***If the primary policy holder is someone other than yourself, please provide the following:**

Policy Holder Name _____ Relation to Patient _____

Policy Holder DOB _____ Policy Holder Social Sec # _____

Primary Complaint:

What is your Primary foot complaint today? _____

This problem started: -- Days / Weeks / Months / Years Ago **The problem is:** Better / Worse / Unchanged

Does this affect your ability to walk? -- **Does this affect your ability to exercise?** --

Was this a result of trauma? -- **Was this a job-related injury?** --

*If this was the result of an injury, please note when the injury occurred _____

How would you describe your pain? (*Circle all that apply*)

Generalized Localized Throbbing Radiating Burning Numbness Dull Ache Sharp Ache Other

Rate the Severity of your pain: 1 2 3 4 5 6 7 8 9 10 (*most severe*)

What treatments have you tried for this problem? _____

Do you have any other foot problems? _____

Noah Foot and Ankle Center, PLLC
PRIMARY COMPLAINT & MEDICAL HISTORY

Primary Complaint Continued:

Review of Systems: Please circle any symptoms that you are experiencing *TODAY:*

Constitutional	Fever/Chills Decline in Health Weight Loss / Gain Weakness Fatigue	None
Head	Dizziness Fainting Headaches Head Injury Sweats Pain	None
Eyes	Blurry / Double Vision Cataracts Glaucoma Vision Loss Discharge Infections Glasses	None
Respiratory	Asthma Sputum Cough Shortness of Breath Wheezing	None
Cardiovascular	Chest Pain Palpitations Heart Murmur High Blood Pressure Cold Fingers/Toes Swelling of Legs	None
Gastrointestinal	Stomach Pain Nausea Vomiting Diarrhea Constipation Heartburn	None
Musculoskeletal	Arthritis Gout Muscle Stiffness/Cramps Joint Pain/Stiffness Weakness Back Pain	None
Psychiatric	Disturbing Thoughts Excessive Stress Nervousness Mood/Behavioral Changes Disorientation	None
Skin	Rash Eczema Lumps Dryness Itching Skin Color Changes Easy Bruising	None
Neurological	Numbness in Feet Tingling / Burning Memory Loss Tremors Strokes Unsteady Gait	None
Endocrine	Neck Pain Thyroid Problems Cold/Heat Intolerance Increased Thirst Excessive Urination	None

Medical History:

Have you seen another podiatrist in the last 60 days? -- If you circled yes, please note the date _____

Current: Weight _____ Height _____ Shoe Size _____

Primary Care Physician _____ Practice _____ Date last seen _____

Are you currently pregnant or breast feeding? --

***Please Note*: We may take X-Rays/Photos during your visit, so please inform us if there is a chance you may be pregnant. Also, medications we may prescribe (i.e., antibiotics) could change the effectiveness of birth control medications. ***

Immunizations:

Have you had a Flu Vaccine this flu season? -- If you circled yes, please note the date _____

Have you had a Pneumonia Vaccine? -- If you circled yes, please note the date _____

Have you had a Covid-19 Vaccine? -- If you circled yes, please note the date(s)_____ /_____

Diabetic History:

Are you Diabetic? -- If yes, date you were diagnosed _____ Type --

Do you use insulin? -- What was your last A1C reading? _____ Date _____

Medication Information:

Preferred Pharmacy: _____ Location: _____

Are you currently on blood thinners? -- If yes list prescription: _____

***Please list all medications you are currently taking and the dosage** (If you have a current list, we can make a copy.)

(This includes aspirin, birth control pills, over the counter medications and supplements, both vitamin and herbal)

_____ _____

_____ _____

_____ _____

Allergies: (please check all that apply & list any additional in the appropriate space)

- ☐ Adhesives / Tape
- ☐ Eggs
- ☐ Iodine
- ☐ Latex
- ☐ NSAIDS/Anti-Inflammatories
- ☐ Nickel / Metal Jewelry
- ☐ Penicillin
- ☐ Shellfish
- ☐ Sulfa Drugs
- ☐ X-Ray Dye

Other Known allergies: _____

_____

Please list any reaction you may have:

_____

_____

Social History: (Please circle the appropriate response for each)

Smoking Status:	Never Smoked	Former Smoker	Occasional Smoker	Daily Smoker
Alcohol Use:	Non-drinker	Social Drinker	Occasional Drinker	Daily Drinker
Illicit Drug Use:	Never Used	Former User	Current User	

Noah Foot and Ankle Center, PLLC
MEDICAL HISTORY CONTINUED

Medical History: If you have had or currently have any of the following, please check all that apply.

- ☐ Alzheimer's Disease
- ☐ Amputation
- ☐ Anaphylactic Reaction
- ☐ Anemia
- ☐ Anesthesia Reaction
- ☐ Anxiety Disorder
- ☐ Arthritis
- ☐ Rheumatoid Arthritis
- ☐ Asthma
- ☐ Back Pain
- ☐ Benign Prostatic Hyperplasia
- ☐ Birth Control Use
- ☐ Blood Clot History
- ☐ Breast Cancer
- ☐ Broken Bone (location)
- ☐ Cancer
- ☐ Chemical Addiction
- ☐ Circulation Problems
- ☐ Clostridium Difficile Colitis
- ☐ Congestive Heart Failure
- ☐ Coronary Artery Disease
- ☐ COPD / Emphysema
- ☐ Cyst(s) If yes Type? _____
- ☐ Cystic Fibrosis
- ☐ Dementia
- ☐ Depression
- ☐ Dermatitis
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Fibromyalgia
- ☐ GERD
- ☐ Glaucoma
- ☐ Gout
- ☐ Heart Attack
- ☐ Heart Disease
- ☐ Heartburn
- ☐ Hepatitis
- ☐ HIV / AIDS
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Irritable Bowel Syndrome
- ☐ Kidney Disease
- ☐ Kidney Stone
- ☐ Large Scars / Keloids
- ☐ Liver Disease / Condition
- ☐ Melanoma
- ☐ Memory Loss
- ☐ Menopause
- ☐ Mitral Valve Prolapse
- ☐ Neuropathy
- ☐ Osteopenia
- ☐ Osteoporosis
- ☐ Pacemaker
- ☐ Pneumonia
- ☐ Psoriasis
- ☐ Pulmonary Embolism
- ☐ Reflux
- ☐ Seizure Disorder
- ☐ Skin Ulcer(s)
- ☐ Sleep Apnea / CPAP
- ☐ Stomach Ulcer(s)
- ☐ Stroke (CVA / TIA)
- ☐ Traumatic Brain Injury
- ☐ Tuberculosis

Surgical History: Please list any previous surgeries & any important details.

_____ _____

_____ _____

Family History: Please check all that apply.

- ☐ Alcoholism
- ☐ Alzheimer's Disease
- ☐ Anxiety
- ☐ Arthritis
- ☐ Autoimmune Disease
- ☐ Bleeding Disorders
- ☐ Blood Clot(s)
- ☐ Breast Cancer
- ☐ Bunions/Foot Deformities
- ☐ Cancer
- ☐ Dementia
- ☐ Diabetes
- ☐ Glaucoma
- ☐ Heart Disease
- ☐ Other Heart Problems
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Kidney Disease
- ☐ Liver Disease/Problems
- ☐ Lupus
- ☐ Malignant Melanoma
- ☐ Neurologic Disease
- ☐ Peripheral Vascular Disease
- ☐ Pulmonary Embolism
- ☐ Rheumatoid Arthritis
- ☐ Stroke
- ☐ Thyroid Disease

Other: _____

*__Informed Consent:__ I understand that all specimens/cultures collected in accordance with my treatment will be sent to pathology and I am responsible for any fees associated with those services. I give my permission to the doctor to administer and perform such procedures as may be deemed necessary in the diagnoses and/or treatment of my feet. I understand that the completeness and accuracy of this information is critical to receiving safe and effective medical care. I have completed this form to the best of my ability; therefore, I certify that the above information is true and correct to the best of my knowledge. If you would like a copy of your continued care document from today, please notify the front desk. There is a three-day minimum turn around and there may be a fee associated with this request.

Signature: _____ Date: _____

(Parent or Legal Guardian if Patient is a Minor)

Noah Foot and Ankle Center, PLLC
HIPAA

Release of Protected Health Information (Information may be released to the following individual(s)):

Name _____Relationship to Patient _____ Phone _____

Name _____Relationship to Patient _____ Phone _____

I **authorize** limited confidential medical voice messages to be left on my preferred contact information

PATIENT AGREEMENT AND AUTHORIZATION FOR MEDICAL TREATMENT

Patient Name: _____ D.O.B. _____

Office, Practice/Clinic personnel at this facility are hereby authorized to administer any medical, diagnostic or therapeutic treatment, as may be deemed necessary or advisable. I have the right to consent or refuse consent, to any proposed procedure or therapeutic course, absent emergency or extraordinary circumstances.

BENEFITS TO PHYSICIAN & ASSIGNMENT OF BENEFITS:
I hereby authorize payment directly to the physician of the surgical and/or medical benefits. I understand my insurance policy is a contract between me and my insurance company and it is my responsibility to verify benefits and coverage. I accept financial responsibility at ***time of service*** for payment of any deductible, co-insurance, and other balances not paid by my insurance company. I also agree that physician benefits otherwise payable to the insured are to be made payable to the physician responsible for my care. Any payment received for this period may be applied to any unpaid bills for which I am liable, subject to the rules of coordination of benefits. Refusal to authorize assignment of benefits will require payment in full by cash, check or credit card at the time of service.

PRE-CERTIFICATION-POLICY
I understand that this Office, Practice/Clinic will assist with insurance precertification requirements, but will not assume responsibility or any impact which it may have on insurance payment.

RELEASE OF INFORMATION:
The information authorized for release may include information which may be considered a communicable or venereal disease, including hepatitis, syphilis, gonorrhea, HIV & AIDS. I hereby give my permission to Nicholas C. Noah, DPM to administer treatment and to perform such minor operative procedures as may be deemed necessary in the diagnosis and/or treatment of my condition. I understand all of the above and hereby state that the information is correct to the best of my knowledge.

CERTIFICATION
I hereby certify that I have read each of the above statements, have had each item explained to me to my satisfaction, and have been offered a copy of this Patient Agreement. I further certify that I am the patient or duly authorized by the patient to accept the terms of this Patient Agreement. A photo copy of this document has the same effect as an original.

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES:
A complete description of how your medical information will be used and disclosed by this Office, Practice/Clinic is in our NOTICE OF PRIVACY PRACTICES, which you have received. A copy is posted in this Office, Practice/Clinic.

***I hereby acknowledge receipt of the Notice of Privacy Practices provided to me by Noah Foot and Ankle Center, PLLC.**

_____

Signature of Patient or Legal Guardian if applicable **Relationship to Patient** **Date** **Witness**

Noah Foot and Ankle Center, PLLC

HOUSE RULES

In an effort to provide a safe and healthy environment for the staff, patients, and their families; we ask everyone to refrain from any behaviors that are disruptive or pose a threat to the rights or safety of other patients and staff. Please be patient with the staff, sometimes appointments run behind. Please keep in mind that some patients need extra attention for their unforeseen conditions. Please treat the staff and physician with respect. Any harassing, offensive, or intimidating statements or threats of violence are not tolerated and will lead to immediate dismissal from our practice. We will try to keep you informed as much as possible, and see you as quickly as we can, or reschedule your appointment as soon as possible. Please note the following:

LATE APPOINTMENTS

Please allow yourself time to make your scheduled appointment. If you are going to be a few minutes late, please notify our office. If you are going to be more than 10 minutes late, we will have to reschedule your appointment.

MISSED VISIT POLICY

We ask that you give our office 24 hours' notice if you are **NOT** going to be able to make your appointment. If you do not call or show up for your appointment, it will be documented as a "no show". If you No Show, Cancel, or Reschedule for your appointment **three** times, you will be charged a fee of $25 per missed visit at which time your account will be locked. Once the $25 fee has been collected, your account will be unlocked to schedule future appointments.

SANITATION

Our restrooms are for patients only, as our staff works very hard to maintain a clean office for all of our patients. We ask that you please respect and help maintain the cleanliness of our office. Please remember that there are other patients who come in behind you for appointments. Be mindful of things that you may be tracking into the office from outside and do your best to help minimize any risk of infection. Outside germs, debris, and pests can be a large health risk for our patients; therefore, we ask that you limit guests to one support person/caregiver during your appointment. Please also be aware of your personal hygiene when coming to your appointments. Our staff have many supplies that you may need to clean up behind yourself readily available for your convenience.

CASH PAYING PATIENTS

Patients that are uninsured are considered cash paying patients. A payment of at least 60% of your total bill is required in the form of cash, credit card, or check at the time of your visit. Arrangements must be made before leaving to pay the rest of the balance in full. If you cannot pay the rest of the balance at the time of service, a written financial agreement for payment will be arranged with you following your appointment. Our office has no way of knowing prior to the date of service what the actual charge for that day's appointment will be. We can give you an estimated cost, but there is no way of knowing until after you have seen the physician.

DELINQUENT BILLS/PAYMENTS

We understand that sometimes medical bills can be quite expensive and overwhelming. We will work with you in any way that we can to take care of these matters. If the accounts receivable department feels that they have made every effort to assist you and the account is still delinquent, further legal action will be taken. If your account with us is delinquent, we will expect you to make payment arrangements with our accounts receivable department **before** a future appointment can be scheduled.

REQUESTING MEDICAL RECORDS/X-RAYS

If you are requesting any medical records (including x-rays) or paperwork, please allow our office 3 business days to process your request. Paperwork may have a charge associated depending on number of pages and depth of documentation needed. For medical records you will need to sign the appropriate authorization/release forms. Please advise the staff of what records you are needing and who/where they need to be sent. We will **NOT** release x-ray records to anyone except the patient without the appropriate authorization forms. Our office will give you a courtesy call to let you know when your paperwork, records, and x-rays are ready to be picked up. There is a service fee of $5.00 for an x-ray CD.

PRESCRIPTIONS

We do not call-in medications after hours, on holidays, or on weekends. Medication needs are the responsibility of the patient. If you need your medication **changed**, please call our office and leave a message for the staff stating your request and what pharmacy you use. If you are in need of medication on Friday or over the weekend, please call by Wednesday afternoon. If you need a **refill** on your prescription(s), please call your pharmacy and they will forward the request to our office. Please call your pharmacy to see if your prescription is ready. Our office considers narcotics/pain medication prescriptions on a case-by-case basis. If you are in need of a refill of a controlled substance, you will need to contact our office directly. These requests will be processed as stated in the above paragraph. Please note our office has access to the North Carolina Narcotics Information report that discloses the filling of all narcotics. If the physician feels that any of these reports show misuse and/or guidelines have been violated, we will not continue to write you narcotics/pain medication prescriptions.

PHONE CALLS

Phone calls will be returned within 24 hours, with the exception of Fridays and Holidays. Please leave a detailed voicemail with a good call back number in order to receive a return call.

_____ *PLEASE INITIAL & DATE THAT YOU HAVE READ AND RECEIVED A COPY OF THE NFA HOUSE RULES (IF REQUESTED)

Noah Foot and Ankle Center, PLLC
MEDICAL RELEASE AUTHORIZATION

Patient Name: _____ DOB: _____

Preferred Phone: _____ Alternate Phone: _____

Address: _____ City, ST, Zip: _____

Please note a copy fee may be charged for medical records

For Office Use Only:

Patient listed above authorizes the following healthcare facility to make record disclosure:

Facility Name: _____

Facility Phone: _____ Facility Fax: _____

Facility Address: _____ City, ST, Zip: _____

Dates and Type of information to disclose:

- ☐ 2 Years prior from date last seen
- ☐ Dates other: _____
- ☐ Specific Information: _____
  _____

The purpose of disclosure is:

- ☐ Change of Insurance or Physician
- ☐ Continuation of Care (e.g., VA Med Ctr)
- ☐ Referral
- ☐ Other: _____

RESTRICTIONS: Only medical records originated through this healthcare facility will be copied unless otherwise requested.

I understand the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

This information may be disclosed and used by the following individual or organization:

Release to: Noah Foot and Ankle Center, PLLC Fax: (910) 399-8690 Phone: (910) 399-8688

Address: 5226 S. College Rd. Suite #4

City, State, Zip: Wilmington, NC 28412

- ☐ Please mail records.
- ☐ Please fax records.

I understand I may revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the health information management department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. **Unless otherwise revoked**, **this authorization will expire 1 year from the date signed.**

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or obtain a copy of the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the authorized individual or organization making disclosure.

I have read the above foregoing Authorization for Release of Information and do hereby acknowledge that I am familiar with and fully understand the terms and conditions of this authorization.

X _____ _____

Signature of Patient / Parent / Guardian or Authorized Representative Date

(Guardian or Authorized Representative must attach documentation of such status.)

_____

Printed name of Authorized Representative Relationship / Capacity to patient Date