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PLEASE PRINT

FIRST NAME _____ MIDDLE _____ LAST NAME _____ SS# _____
DOB _____ AGE _____ GENDER: M F MARITAL STATUS: M S W D
ADDRESS _____ CITY _____
STATE _____ ZIP _____ STUDENT: N/A FT PT WORK STATUS _____
OUT OF STATE ADDRESS _____ CITY/STATE _____ ZIP _____
HOME PHONE _____ WORK PHONE _____ CELL PHONE _____
EMERGENCY CONTACT NAME _____ PHONE _____
EMAIL _____ RACE _____
ETHNICITY _____ PREFERRED LANGUAGE _____
OCCUPATION _____ EMPLOYER _____ START DATE _____
ADDRESS OF EMPLOYER _____
NAME OF SPOUSE _____ SPOUSE'S DOB _____ SPOUSE'S SS# _____
NAME OF PHARMACY _____ PHONE # _____

INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY _____
SECONDARY INSURANCE COMPANY _____

IF MEDICARE, ARE YOU OR YOUR SPOUSE EMPLOYED? YES _____ NO _____

IF NOT COVERED BY HEALTH INSURANCE, PLEASE INDICATE METHOD OF PAYMENT: _____

WHO REFERRED YOU TO THIS OFFICE OR HOW DID YOU HEAR ABOUT US? _____

WHAT IS YOUR REASON FOR SEEING THE DOCTOR TODAY? _____

HOW LONG HAVE YOU HAD THIS CONDITION? _____

NAME OF FAMILY PHYSICIAN _____ DATE LAST SEEN _____

NAME OF ENDOCRINOLOGIST _____ DATE LAST SEEN _____

DATE OF LAST BLOOD SUGAR _____ DO YOU CHECK YOU OWN BLOOD SUGAR REGULARLY? YES ___ NO ___

I HEREBY AUTHORIZE ROBERT W. TINSLEY, D.P.M., P.A. TO FURNISH INFORMATION TO INSURANCE CARRIERS AND/OR OTHER HEALTH PRACTITIONERS CONCERNING MY ILLNESS AND TREATMENT AND I HEREBY ASSIGN TO THE PHYSICIAN ALL PAYMENT FOR MEDICAL SERVICES RENDERED TO MY DEPENDENTS OR MYSELF. I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY AMOUNT NOT COVERED BY MY INSURANCE. THIS IS A LIFETIME AUTHORIZATION.

SIGNATURE: _____ DATE: _____

ROBERT W. TINSLEY, D.P.M.

REVIEW OF SYSTEMS: Please check the appropriate response box for any symptoms you may be currently experiencing.

PATIENT NAME: _____ **DOB:** _____ **DATE:** _____

SYMPTOM	YES	NO
CONSTITUTIONAL		
Chills		
Fatigue		
Fever		
Night Sweats		
Weight Gain		
Weight Loss		
RESPIRATORY		
Coughing up blood		
Persistent cough		
Shortness of breath		
Sleep Apnea		
Wheezing		
CARDIAC		
Angina		
Chest pain or discomfort		
Fainting		
Leg or feet swelling		
Racing or skipping heartbeats		
Wake at night short of breath		

SYMPTOM	YES	NO
GASTROINTESTINAL		
Bloody stool		
Bowel changes		
Heartburn		
Indigestion		
Tarry stool		
Vomiting		
MUSCULOSKELETAL		
Back pain		
Back stiffness		
Joint pain		
Joint stiffness		
Joint swelling		
Sciatica		
NEUROLOGIC		
Change in thinking		
Double vision		
Headache		
History of stroke		
Numbness/tingling/burning of extremities		
Seizures		
Vertigo/Room spinning		
Weakness		

PATIENT SIGNATURE: _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

In addition to the allowable disclosures described in The Provider Notice of Practices, I hereby authorize disclosure of my protected health care information to the persons indicated below.

_____ () YES () NO
Spouse

_____ () YES () NO
Other/Name & Relation

_____ () YES () NO
Other/Name & Relation

_____ Patient Name (Please Print) _____ Date

Parent or Authorized Representative (if applicable)

Signature

Acknowledgement of Receipt of Notice of Privacy Practices

I acknowledge that I have received and understand Robert W. Tinsley DPM PAs *Notice of Privacy Practices* containing a description of the uses and disclosures of my health information. I further understand that Robert W. Tinsley DPM may update its *Notice of Privacy Practices* at any time and that I may receive an updated copy of Robert W. Tinsley DPM PAs *Notice of Privacy Practices* by submitting a request in writing for a current copy of Robert W. Tinsley DPMs *Notice of Privacy Practices*.

Printed Patient Name

Patient Signature

Date

If completed by patient's personal representative, please print name and sign below.

Printed Patient Personal Representative Name

Relationship to Patient

Patient Personal Representative Signature

Date

For Robert W. Tinsley DPM PA Official Use Only

Complete this form if unable to obtain signature of patient or patient's personal representative.

Robert W. Tinsley DPM PA made a good faith effort to obtain patient's written acknowledgement of the *Notice of Privacy Practices* but was unable to do so for the reasons documented below.

Patient or patient's personal representative refused to sign

Patient or patient's personal representative unable to sign

Other _____

Printed Employee Name

Employee Signature

Date