ACKNOWLEDGEMENT OF RECEIPT
OF
NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the notice of Privacy Practices and that I have read (or had the opportunity to read if I so chose) and understood the Notice.

Contact Preferences:

Okay to leave message on your phone/cell with:

___ Patient only
___ Patient and/or spouse
___ Anyone answering the phone

_______________________________________ _______________________

Patient Name (please print) Date

____

Parent or Authorized Representative (if applicable)

____

Signature

SUMMARY OF NOTICE OF PRIVACY PRACTICES

Uses and Disclosures of Health Information: We will use and disclose your health information in order to treat you or to assist other health care providers in treating you. We will also use and disclose your health information in order to obtain payment for our services or to allow insurance companies to process insurance claims for services rendered to you by us or other health care providers. Finally, we may disclose your health information for certain limited operational activities such as quality assessment, licensing, accreditation and training of students.

Uses and Disclosures Based on Your Authorization: Except as stated in more detail in the Notice of Privacy Practices, we will not use or disclose your health information without your written authorization.

Uses and Disclosures Not Requiring Your Authorization:
In the following circumstances, we may disclose your health information without your written authorization:

- To family members or close friends who are involved in your health care;
- For certain limited research purposes;
- For purposes of public health and safety;
- To Government agencies for purposes of their audits, investigations and other oversight activities;
- To government authorities to prevent child abuse or domestic violence;
- Tot the FDA to report product defects or incidents;
- To law enforcement authorities to protect public safety or to assist in apprehending criminal offenders;
- When required by court orders, search warrants, subpoenas and as otherwise required by law.

Patient Rights: As our patient, you have the following rights:

- To have access to and/or a copy of you health information;
- To receive an accounting of certain disclosures we have made of your health information;
- To request restrictions as to how your health information is used or disclosed;
- To request that we communicate with you in confidence;
- To request that we amend your health information;
- To receive notice of our privacy practices.

DATE:______________

Dr. Stephan J. LaPointe
D.P.M.,PhD.

PATIENT INFO:

NAME: FIRST____________________MI___LAST____________________________

ADDRESS____

CITY____________________________STATE_________ ZIP__________________

SS# __________________________DOB ___/___/___ AGE: _____SEX: M__F__

PHONE ( ) _____________ CELL PHONE ( ) _______________EXT________

E-MAIL___________________________EMPLOYER _________________________

MARITAL STATUS: SINGLE______MARRIED_____DIVORCED_____OTHER___

SPOUSE'S NAME: __________________SS# _______________DOB ___/___/___

SPOUSE'S EMPLOYER ____________________ WORK NUMBER______________

RESPONSIBLE PARTY (IF OTHER THAN PATIENT)

NAME: ____________________________RELATIONSHIP ____________________

DOB: ______/______/______ SS# ______________________________

ADDRESS:__________________________CITY_____________STATE_____________

PHONE: ( )________________ EMPLOYER:______________________________

WORK PHONE# _____________________ EXT_______________

EMERGENCY CONTACT NOT LIVING WITH YOU:

NAME; __________________________________

RELATIONSHIP:____________________

PHONE:_____________________

Georgia Foot and Ankle Specialists
409 West 10th St.
Rome, GA 30165

Consent for Treatment

I hereby give Dr. LaPointe and/or his associate's permission to examine and treat my foot or leg problems. If insurance is filed, I authorize payment to be made to me, or the doctor. I further authorize the release of any medical information necessary to process claims. I accept full responsibility for any charges on this account. I understand that should I neglect to pay my bill and allow my account to be turned over to a collection agency, a collection fee of up to 40% of the balance due will be added back to my account. I understand it is my responsibility to understand my insurance benefits and that this office is happy to provide care within my insurance companies guidelines as long as I make them aware of these guidelines. If I do not properly inform the office of special requirements, and services/supplies are ordered that are not covered, I will be billed for the charge. With cooperation between this office and myself, I should be able to receive all of the benefits offered, while being able to concentrate on caring for my medical needs. I have read and understand the office policy stated above and agree to accept responsibility as described.

Patient Name (print please) ______________________________

Patient Signature ____________________________________
Date ______________

Guardian or legal representative ___________________________
Date_________

Relationship to patient _________________________________

GEORGIA FOOT & ANKLE SPECIALIST
409 West 10th St.
Rome, GA 30165
706-232-3888 office 706-232-8099 fax

Dear Patient;

I, Dr. LaPointe, will be sending a record of your office visit(s) to your doctor(s).
Please answer the questions below.

Patient Full Name ____________________________________

Date of Birth _______________________

Referring Physician;
Doctor's Full Name ____________________________________

Location of doctor's office (city & state)___________________________

Primary Care Physician;
Doctor's Full Name ____________________________________

Location of doctor's office (city & state) ___________________________

Endocrinologist
Doctor's Full Name _______________________________________

Location of doctor's office (city & state)____________________________

Vascular Physician;
Doctor's Full Name ____________________________________

Location of doctor's office (city & state) ____________________________

Thank you for your cooperation,

Dr. Stephan J. LaPointe

Welcome to Georgia Foot & Ankle Specialists

409 West 10th St., Rome, GA 30165
706-232-3888 O - 706-232-8099 F
Dr. Stephan LaPointe D.P.M./Ph.D.

Name: ______________________________________ **DOB:** _________/________/__________

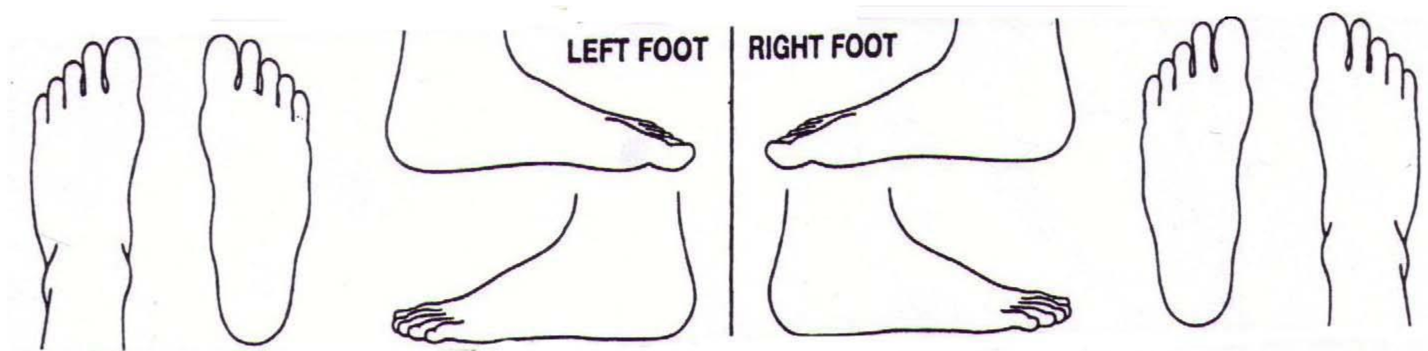
Who referred you to our office? ____*Physician (Dr. Name*______________________*)* _____*Patient*
_____*Friend/family* _____*Phonebook* ___*Website* _____*Radio Ads* _____*Insurance co*

Describe your primary foot or ankle concern:

Brief description of the concern: ____

___right foot ___left foot ___right ankle ___left ankle ___right leg ___left leg ___toes

Please locate the pain on the following diagrams:



If you have pain, describe the nature of the pain:

___dull ___ache ___sharp ___electrical ___burning ___numbing ___tingling

other: ____

How often does it hurt or affect you?

___at all times ___daily ___weekly ___worse at night ___worse in morning

other: ____

How long has been (enter number)? #:____ days #:_____weeks #:______months #:_______years

How has the issue progressed: ___about the same ___getting better ___getting worse

Describe any treatment for this problem: ____

Does anything make it worse? ____

Does anything make it better? ____

Are there any hobbies or activities that are restricted? ____

Medical History - Please check if **you** have any of the following conditions:

___ acne
___ Alzheimers disease
___ ashma
___ back pain
___ cancer
___ cardiovascular hx
___ COPD
___ depression
___ diabetes
___ DVT
___ firbomyalsia
___ GERD
___ headaches
___ hepatisis
___ hypertension
___ kidney disease
___ liver disease
___ lung disease
___ multiple sclerosis
___ neck pain
___ neuropathy
___ obesity
___ parkinson's
___seizures
___ sleep apnea
___ stroke
___ thyroid disorder
___ urinary infection
___ ulcer foot
other:________________
other:________________
other:________________

Family History - Please check if **blood relatives** have any of the following conditions:

___anemia ___mother ___father
___arthritis ___mother ___father
___asthma ___mother ___father
___back pain _ _mother ___father
__blood clot ___mother ___father
___cancer, breast __m __f
___cancer, cervical __m __f
___cancer, stomach __m __f
___cancer, skin __m __f
___carotid disease ___m ___f
___depression _mother ___father
___diabetes type I __m __f
___diabetes type II __m __f
___gout __m __f
___heart disease __m __f
___heart surgery __m __f
___heart valve dx __m __f
___ high blood pressure __m __f
___ high cholesterol __m __f
___ HIV positive __m __f
___hypothyroidism __m __f
___kidney disease __m __f
___liver disease __m __f
___lupus __m __f
___neuropathy __m __f
___rheumatoid arthritis __m __f
___stroke __m __f
___stroke mini (TIA) __m __f
___ulcer foot __m __f
other:________________
other:________________
other:________________

Shoe Size: ____ Height: _____ Weight: _____ **Referring Physician** ________________________

Primary Care Physician: _______________________ Vascular Physician ________________________

Retained hardware (metal of any kind in your body): ____Yes ____No Type:_____________________

SURGICAL HISTORY

Foot & Ankle & Leg Surgery

___Achilles lengthening
___amputation of foot
___amputation of leg
___amputation of toe
___ankle fracture repair
___ankle scope
___bypass of leg arteries
___fibroma removal
___ganglion removal
___hammertoe repair
___heel spur removal
___heel plantar fascia
___neuroma
___stents in leg arteries
___toenail removal/ingrown
___vein stripping
___wart removal
other:_________________

Other surgery

___c-section
___gall bladder
___hernia repair
___hip replacement
___hysterectomy
___kidney removal
___knee arthroscopy
___knee replacement
___low back surgery
___neck surgery
___shoulder surgery
___carpel tunnel surgery

other:________________________
____

Review of Systems: Please check symptoms you are *currently* experiencing

Constitutional:___WNL

___fever ___chills ___headache
___other

Eyes: ___WNL

___blurred vision ___cataracts
___light sensitivity ___glasses or contacts
___watery eyes ___glaucoma
___foreign body

Ears, Nose, Throat, Mouth: ___WNL

___congestion ___ringing in ears
___drainage ___pain
___difficulty swallowing ___bleeding

Skin: __ WNL

___skin rash ___persistent itch ___pain or soreness eye
___boils ___tattoo ___redness

Allergies : __none

___Hay fever
___Drug allergies

Musculoskeletal: ___WNL

___joint pain ___weakness ___limited motion or mobility
___back pain ___gout
___leg cramps ___back pain

GI: ___none

___abdominal pain ___nausea/vomiting ___indigestion/heartburn

Cardiac: ___WNL

___chest pain ___irregular heat beat ___orthopnea
___palpatations ___PVD

Hematological: ___WNL

___swollen glands ___easily bruising - bleeding
___blood clotting problems ___past transfusion

Psychiatry: ___ WNL

___not satisfied with lift ___have considered suicide ___panic attacks
___depression ___forgetful/memory loss

Social History

Alcohol: ___None ___Rare ___Socially ___1-2 drinks per day ___more than 2 drinks per day

Smoker /Tobacco ___Yes ___No ___Quit Number of packs _______per day for ______years

Marital Status: ___Single ___ Married ___Divorced ___Widow(er)

Occupation: ____

Are you a patient at a pain management clinic? **Yes____** **No _____**

Pain Management Physician's Name___________________________________

Iam currently not taking any medication ______

PLEASE LIST ALL THE MEDICATION YOU TAKE:

MEDICATION	DOSE	TIMES PER DAY	PURPOSE

Please circle all pain medications, from the

Tylenol #3 Empirin

Vicodin Lorcet

Vicoprofen Norco

Darvocet Darvon

Percocet Actiq

Percodan Fentanyl

Dilaudid Hydrocodone

Duragesic Oxycontin

Oxy-IR Demerol

Kadian MS Contin

Avinza Morphine

PLEASE LIST ALL MEDICATIONS YOU ARE ALLERGIC TO:

I have NO known allergies. _____

MEDICATION	REACTION IT CAUSED

PHARMACY _____________________________________ **Telephone #** _________________________

Immunizations: Date of last tetanus shot____