



**Established Patient Update**

Name \_\_\_\_\_ DOB \_\_\_\_\_ Pref. Phone # \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_

Primary Insurance \_\_\_\_\_ 2ndary \_\_\_\_\_

E-Mail Address \_\_\_\_\_ Pharmacy \_\_\_\_\_

Current Height \_\_\_\_\_ Weight \_\_\_\_\_ Describe your current foot complaints \_\_\_\_\_

Primary Care Physician \_\_\_\_\_ Date Last Seen by PCP \_\_\_\_\_

List any illnesses newly diagnosed in the last 12 months \_\_\_\_\_

Do you have a medication list to copy today? Yes \_\_\_\_ No \_\_\_\_ (If no please list medication and dosage) \_\_\_\_\_

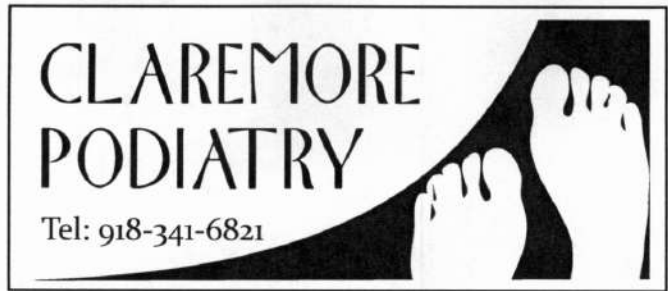
Allergies \_\_\_\_\_

Surgeries or Hospitalizations in last 12 months \_\_\_\_\_

Tobacco (CIRCLE ONE):    Never Used            Current User            Past User/Quit Date \_\_\_\_\_

I hereby certify that the above information is accurate to the best of my knowledge.

Signature \_\_\_\_\_ Date \_\_\_\_\_



We are required by law to maintain the privacy of, and provide individuals with, a notice of our legal duties and privacy practices with respect to your protected health information. If you have any objections to our privacy practices please ask to speak with our HIPAA Compliance Officer in person or by phone at the number listed above.

My signature below is only an acknowledgement that I have been notified of Claremore Podiatry's Privacy Policies and Practices. I am aware that a copy of said practices is available upon my request.

Signature \_\_\_\_\_ Date \_\_\_\_\_

In addition to those parties listed in Claremore Podiatry's Privacy Practices, and those required by law (i.e. medical care providers and insurance carriers) I give my permission for Claremore Podiatry to speak with and/or release my medical care and treatment information to the following individual(s):

|                   |                     |
|-------------------|---------------------|
| Release To: _____ | Relationship: _____ |
| _____             | _____               |
| _____             | _____               |

I understand that I may revoke this consent at any time prior to the 12 month automatic expiration date of my signature. However, my revocation cannot be applied retroactively once my PHI has been released in good faith. I understand that Claremore Podiatry and its staff, employees, officers and directors cannot be responsible for the confidentiality of information disclosed after said information has been released pursuant to this authorization, and I hereby release them from any liability arising from such disclosure and from all legal responsibility or liability that may arise from this authorization.

**PATIENT**/Legal Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_ Patient Date of Birth: \_\_\_\_\_

Witness Signature: \_\_\_\_\_ Date: \_\_\_\_\_