CLAREMORE PODIATRY
Tel: 918.341.6821

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 _____

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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: _____