TIMPANOGOS FOOT & ANKLE

Dr. Alexander P. Ramirez, DPM

PATIENT INFORMATION

Name:	Date of Birth:	Phone:	
Mailing Address:	City	State:	Zip:
E-mail Address:	Race/Ethnicity: ❑American Indian or Alaskan Native ❑ Native Hawaiian or other Pacific Islander ❑ Black/African American ❑ Asian ❑ White ❑ Hispanic/Latino		
Sex: ❑ Male ❑ Female / Preferred Language:			

EMPLOYMENT INFORMATION

Employed: ❑ Yes ❑ No	Employer:	Occupation:

RESPONSIBLE PARTY INFORMATION

Person Responsible for Medical Expenses:	Relationship to Patient:	Phone:	
Address (If different from above):	City	State:	Zip:

PRIMARY INSURANCE INFORMATION

Insurance Company:	Policy Number:		
Policyholder's Name:	Relationship to Patient:		
Address of Insurance Company:	City:	State:	Zip:

SECONDARY INSURANCE INFORMATION

Insurance Company:	Policy Number:		
Policyholder's Name:	Relationship to Patient:		
Address of Insurance Company:	City:	State:	Zip:

EMERGENCY CONTACT INFORMATION

Personal Contact In Case of Emergency (Other than Spouse):	Relationship to Patient:
Address City State Zip	Phone:

AUTHORIZATION

I authorize the release of any medical information necessary to process claims for payment. I permit a copy of this authorization to be used in place of the original. I authorize direct payment of benefits to Dr. Alexander P. Ramirez DPM for services rendered. I realize I am responsible for payment of charges not covered by insurance. I certify that the information I have reported regarding my insurance coverage is correct.

Patient/Guardian Signature:	Date:

150 North Main, Suite 202 Heber City, UT 84032 (435) 671-4726 Fax: (435) 654-4026

Dr. Alexander P. Ramirez DPM

PATIENT HEALTH HISTORY

All Information contained in this history is strictly confidential and will be considered a part of your medical record

Name: ____________________________________**Date:**_________________________
Primary Care Doctor: ____
How did you find out about our office?_______________________________________
Chief Complaint: What is the reason for your visit today?
____
____
____

Past Medical History: Please check all that apply to you:

- ☐ **None**
- ☐ Rheumatoid Arthritis
- ☐ Depression
- ☐ Heart surgery
- ☐ Stroke
- ☐ Epilepsy/Seizures
- ☐ Cancer: _______________________
- ☐ Diabetes
- ☐ Heart disease
- ☐ High blood pressure
- ☐ Previous Foot Pain/Surgery
- ☐ Psychiatric Disease

Please list any other medical condition(s) your primary doctor or other doctors have diagnosed: ____

Previous Surgeries: Please list past surgeries with approximate date:

Procedure	***Date***
___________________	____________________________
___________________	____________________________
___________________	____________________________
___________________	____________________________
___________________	____________________________

Medications: Please list any medications you are taking with dose and frequency:

Medication	***Dose/Frequency***
___________________	____________________________
___________________	____________________________
___________________	____________________________
___________________	____________________________
___________________	____________________________
___________________	____________________________
___________________	____________________________

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Allergies: please list any medical allergies that you have:

Medication	***Describe Reaction***
________________	__________________________
________________	__________________________
________________	__________________________

Family History: Any blood relative who has or had:

☐ **None**
☐ Aneurysm
☐ Asthma
☐ Cancer, Type: _______________
☐ Depression
☐ Diabetes
☐ Epilepsy/Seizures
☐ Heart disease
☐ Heart surgery
☐ High blood pressure
☐ Kidney Disease
☐ Lung Disease
☐ Migraine
☐ Multiple Sclerosis
☐ Psychiatric Disease
☐ Stroke
☐ Thyroid Disease
☐ Previous Foot Pain/Surgery

Other:____

Social History:

Do you drink alcohol? ☐ Yes ☐ No ☐ Quit

Do you smoke or use tobacco? ☐ Yes ☐ No ☐ Quit

If yes, circle which best describes you?

Current every day smoker   Current occasional smoker

Comments:

____

____

____

____

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Dr. Alexander P. Ramirez DPM

Patient Name ____ Date of Birth______________

Purpose
This form allows you (the "Patient") to give Timpanogos Foot and Ankle providers permission (authorization) to disclose your protected health information (PHI) to a person that will act as your Personal Representative. The information covered by this authorization is protected health information including diagnoses, procedures, billing data, and treatment plans.

Each patient who wishes to name a personal Representative must complete an authorization form. For example, if you expect your spouse to call us on your behalf, you need to fill out this form. If you do not wish to name a Personal Representative, please indicate below. You are not required to name a Personal Representative, but if you do not, we will not release your protected health information to anyone else who may call or write on your behalf. Your Personal Representative may be anyone of your choosing, such as a spouse, parent, child, friend, and you must provide the information below for each person before we can treat that person as your Personal Representative. If you need additional forms, we will be happy to copy this form for you.

Please Note: This authorization does not give your Personal Representative authority, either implied or direct, over any treatment or direct care decisions.

Authorized Use and/or Disclosure
I understand that Timpanogos Foot and Ankle privacy practice is to not disclose my personal health information except for the purpose of treatment, payment, and health care operations, or as required by law without my written authorization. For this reason, I authorize you to disclose my protected health information to the person(s) named below for the purpose of assisting with or facilitating my health care and payment of any health benefits. I acknowledge that my authorization is voluntary.

I understand that I have the right to limit the information you release under this authorization. Any such limitations must be described in Restrictions in this section.

Personal Representative 1 *(Please print clearly)*

Full Name____ Phone Number_______________
Relationship to You__________________________________ Restrictions ________________________________

Personal Representative 2 *(Please print clearly)*

Full Name____ Phone Number_______________
Relationship to You__________________________________ Restrictions ________________________________

This authorization to release information to my Personal Representative will automatically expire in three (3) years after the date of my last visit to Timpanogos Foot And Ankle.

I understand that I have the right to revoke or end this authorization at any time and may do so by giving written notice of my decision to the Privacy Official at the office of Timpanogos Foot and Ankle, I understand that my revocation of this authorization will not affect any action that has been taken or information that has already been released, based upon this authorization, before receiving my request to revoke authorization.

I have had full opportunity to read and consider the content of this form. I understand that by signing this form, I am confirming my authorization that Timpanogos Foot and Ankle may disclose my protected health information to the person (s) named on this form, for the purpose described above.

I understand that Timpanogos Foot and Ankle may use medical images for advertisement and social media to promote the practice. This will be done without any personal information disclosed and in accordance with HIPAA.

Routine Results Contact / Confirming Appointments
Permission is given for Timpanogos Foot and Ankle to leave routine exam results & confirm office visits:
(check all that apply & preferred number)

- o Home answering machine : _____________________
- o Cell phone: __________________________________
- o Email: ______________________________________

Signature____ Date ________________

Dr. Alexander P. Ramirez DPM

ACKNOWLEDGMENT

I understand that, under the *Health Insurance Portability & Accountability Act of 1996* (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been informed by you of your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such *Notice of Privacy Practices* prior to signing this consent. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Patient Name ____

Signature ____

Relationship to Patient (if minor) _______________________________________

Date ____

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