BARONNE FOOT CENTER
Dr. Lon M. Baronne, DPM, FACFAOM
Dr. George R. Smith, DPM
Dr. Noah G. Oliver, DPM

PATIENT INFORMATION

DATE: _____

PATIENT NAME: _____ SOCIAL SECURITY #: _____
(First) (MI) (Last)

DATE OF BIRTH: _____ MARITAL STATUS: S / M / W / D SEX: Male / Female
MM/DD/YYYY

MAILING ADDRESS: _____
(Street or P.O. Box) (City) (State) (Zip Code)

HOME PH. #: _____ CELL PH. #:_____

EMAIL ADDRESS:_____

PATIENT'S EMPLOYER: _____

FAMILY DOCTOR: _____

PRESENT FOOT PROBLEMS: _____

DID A DOCTOR OR PATIENT REFER YOU TO OUR OFFICE? Y / N NAME:_____

BILLING INFORMATION

Parent or person responsible for bill: _____

TREATMENT AND FINANCIAL AGREEMENT: I hereby apply for treatment by Baronne Foot Center. This treatment shall include x-rays, injections, and such procedures as the office deems necessary. These procedures are always charged separately in addition to the office visit. I accept full responsibility for any charges incurred for services rendered.

INSURANCE ASSIGNMENT: This will authorize the filing of any insurance in force and the direct payment to the Baronne Foot Center any amounts due to my claim under the above-stated policy or policies. I understand that I am financially responsible for charges not covered by benefits due under this authorization. Release of information necessary for the completion of insurance forms is authorized.

I hereby authorize the release of medical information on my behalf as may be deemed necessary by Baronne Foot Center.

_____ _____
Patient/Parent or Guardian Witness

NOTICE OF PRIVACY PRACTICES (HIPAA)
For Baronne Foot Center

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

SIGNATURE:_____

1. RACE: (CIRCLE ONE)

AMERICAN INDIAN **ALASKAN NATIVE** **ASIAN** **AFRICAN AMERICAN** **HISPANIC** **WHITE**

NATIVE HAWIIAN OR OTHER PACIFIC ISLANDER

2. ETHNICITY: (CIRCLE ONE)

NOT HISPANIC OR LATINO **HISPANIC OR LATINO**

3. PREFERRED LANGUAGE: _____

4. BARONNE FOOT CENTER PHYSCIAN: (CIRCLE ONE)

DR.BARONNE DR.SMITH DR.OLIVER

5. PREFERRED COMMUNICATION: (CIRLCE ONE)

MAIN PHONE CELL PHONE WORK PHONE EMAIL

I hereby authorize the release of medical information on my behalf to:

Name:_____ **Relationship:** _____

Name:_____ **Relationship:** _____

Name:_____ **Relationship:** _____

PATIENT PORTAL ONLINE ACCESS

I have been informed about the Patient Portal Online Access and authorize Baronne Foot Center to activate my patient portal account using the email address indicated below. I understand that it is my responsibility to safeguard the email address and my patient portal password in order to maintain the security and privacy of my personal health information. I also understand that the patient portal is not to be used for urgent medical needs nor does it replace the need for me to keep my regular appointments with my doctor.

PORTAL ACCEPTANCE

Patient Name: _____

DOB: _____

PORTAL DECLINE

Signature:_____

Date: _____