Robert W. Tinsley, D.P.M., P.A.
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PLEASE PRINT

FIRST NAME ____________ MIDDLE ________ LAST NAME ____________ SS# ____________

DOB ______________ AGE ________ GENDER: M F MARITAL STATUS: M S W D

ADDRESS ______________________________ CITY ____________

STATE ________ ZIP ________ STUDENT: N/A FT PT WORK STATUS ____________

OUT OF STATE ADDRESS ____________________ CITY/STATE ____________ ZIP ______

HOME PHONE ____________________ WORK PHONE ____________________

CELL PHONE ______________ WE WILL TEXT YOUR APPOINTMENT REMINDER TO YOU.

EMERGENCY CONTACT NAME ______________ RELATIONSHIP ________ PHONE ____________

EMAIL ______________________________ RACE ____________________

ETHNICITY ____________________ PREFERRED LANGUAGE ____________________

OCCUPATION ______________ EMPLOYER ______________________________

ADDRESS OF EMPLOYER ____

SPOUSE'S NAME ______________________________ SPOUSE'S DOB ____________

SPOUSE'S SS# ______________ FOR INSURANCE ONLY

NAME OF PHARMACY ______________________ PHONE # ____________________

INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY ____

SECONDARY INSURANCE COMPANY ____

IF MEDICARE, ARE YOU OR YOUR SPOUSE EMPLOYED? YES ___ NO ___

IF NOT COVERED BY HEALTH INSURANCE, PLEASE INDICATE METHOD OF PAYMENT: ____________

* *

WHO REFERRED YOU TO THIS OFFICE OR HOW DID YOU HEAR ABOUT US? ____________________

WHAT IS YOUR REASON FOR SEEING THE DOCTOR TODAY? ______________________________

HOW LONG HAVE YOU HAD THIS CONDITION? ____

NAME OF FAMILY PHYSICIAN ______________________ DATE LAST SEEN ____________

NAME OF ENDOCRINOLOGIST ______________________ DATE LAST SEEN ____________

DATE OF LAST BLOOD SUGAR ________ DO YOUR CHECK YOUR OWN BLOOD SUGAR REGULARLY? YES ___ NO ___

I HEREBY AUTHORIZE ROBERT W. TINSLEY, D.P.M., P.A. TO FURNISH INFORMATION TO INSURANCE CARRIERS AND/OR OTHER HEALTH PRACTITIONERS CONCERNING MY ILLNESS AND TREATMENT AND I HEREBY ASSIGN TO THE PHYSICIAN ALL PAYMENT FOR MEDICAL SERVICES RENDERED TO MY DEPENDENTS OR MYSELF. I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY AMOUNT NOT COVERED BY MY INSURANCE. THIS IS A LIFETIME AUTHORIZATION.

SIGNATURE: ______________________________________ DATE: ____________

PLEASE SEE BACK OF THIS FORM

MEDICAL HISTORY / FAMILY HISTORY Patient Name: _____

Number of brothers/sisters: B _____ S _____ Deceased? B _____ S _____ Cause of death: _____

Mother/Father - Deceased: M _____ F _____ Cause of Death: M _____ F _____

M - Mother, F - Father, B - Brother, S - Sister, Self

M	F	B	S	Self	
					Cancer
					Diabetes
					Arthritis
					Hepatitis
					Gout

M	F	B	S	Self	
					Stomach Ulcers
					Leg Cramps Walking
					Liver Disease Chest
					Pain
					Heart Condition

M	F	B	S	Self	
					Shortness Breath
					Intestinal Disease
					Kidney Disease
					Hypertension
					NONE

OTHER: _____

_____

ARE YOU ALLERGIC TO THE FOLLOWING?

Please circle: Penicillin Aspirin Novocain Codeine Sulfa NONE

Other allergic medications: _____

SURGICAL HISTORY - Have you ever had any of the following procedures?

☐ Foot Surgery ☐ Appendectomy ☐ Gallbladder Surgery ☐ Tonsillectomy/Adenoidectomy

☐ Heart Surgery ☐ Hysterectomy ☐ Intestinal Surgery ☐ Artery Bypass Surgery on Legs

☐ Hemorrhoidectomy ☐ Hernia Repair ☐ Eye Surgery ☐ NONE

OTHER: _____

SOCIAL HISTORY:

ARE YOU A FORMER SMOKER? ☐ NO ☐ YES QUIT DATE _____

DO YOU CURRENTLY SMOKE? ☐ NO ☐ YES # OF PACKS A DAY _____

DO YOU DRINK ALCOHOLIC BEVERAGES: ☐ NO ☐ YES #/ DAY _____ ☐ Beer ☐ Wine ☐ Hard Liquor

DO YOU OR HAVE YOU EVER USED RECREATIONAL DRUGS? ☐ NO ☐ YES

PRESENT MEDICATIONS - Include Dosage & Frequency

1. _____ 2. _____ 3. _____

4. _____ 5. _____ 6. _____

7. _____ 8. _____ 9. _____

ROBERT W. TINSLEY, D.P.M.

REVIEW OF SYSTEMS: Please check the appropriate response box for any symptoms you may be currently experiencing.

PATIENT NAME: _____ **DOB:** _____ **DATE:** _____

SYMPTOM	YES	NO
CONSTITUTIONAL		
Chills		
Fatigue		
Fever		
Night Sweats		
Weight Gain		
Weight Loss		
RESPIRATORY		
Coughing up blood		
Persistent cough		
Shortness of breath		
Sleep Apnea		
Wheezing		
CARDIAC		
Angina		
Chest pain or discomfort		
Fainting		
Leg or feet swelling		
Racing or skipping heartbeats		
Wake at night short of breath		

SYMPTOM	YES	NO
GASTROINTESTINAL		
Bloody stool		
Bowel changes		
Heartburn		
Indigestion		
Tarry stool		
Vomiting		
MUSCULOSKELETAL		
Back pain		
Back stiffness		
Joint pain		
Joint stiffness		
Joint swelling		
Sciatica		
NEUROLOGIC		
Change in thinking		
Double vision		
Headache		
History of stroke		
Numbness/tingling/burning of extremities		
Seizures		
Vertigo/Room spinning		
Weakness		

PATIENT SIGNATURE: _____

ACKNOWLEDGEMENT OF RECEIPT
OF
NOTICE OF PRIVACY PRACTICES

In addition to the allowable disclosures described in The Provider Notice of Practices, I hereby authorize disclosure of my protected health care information to the persons indicated below.

_____ ( ) YES ( )NO

Spouse

_____ ( ) YES ( )NO

Other/Name & Relation

_____ ( ) YES ( )NO

Other/Name & Relation

_____ _____

Patient Name (Please Print) Date

_____

Parent or Authorized Representative (if applicable)

_____

Signature

Acknowledgement of Receipt of Notice of Privacy Practices

I acknowledge that I have received and understand Robert W. Tinsley DPM PAs *Notice of Privacy Practices* containing a description of the uses and disclosures of my health information. I further understand that Robert W. Tinsley DPM may update its *Notice of Privacy Practices* at any time and that I may receive an updated copy of Robert W. Tinsley DPM PAs *Notice of Privacy Practices* by submitting a request in writing for a current copy of Robert W. Tinsley DPMs *Notice of Privacy Practices.*

Printed Patient Name

Patient Signature

Date

If completed by patient's personal representative, please print name and sign below.

Printed Patient Personal Representative Name

Relationship to Patient

Patient Personal Representative Signature

Date

For Robert W. Tinsley DPM PA Official Use Only
Complete this form if unable to obtain signature of patient or patient's personal representative.

Robert W. Tinsley DPM PA made a good faith effort to obtain patient's written acknowledgement of the *Notice of Privacy Practices* but was unable to do so for the reasons documented below.

Patient or patient's personal representative refused to sign

Patient or patient's personal representative unable to sign

Other_____

Printed Employee Name

Employee Signature

Date