



James R. Hanna, DPM, PC

Board Certified, American Board of Podiatric Surgery
Diplomate, American Board of Foot and Ankle Surgery

690 Davison Road
Lockport, NY 14094

Phone: (716) 433-8711

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225 Portage Road

Lewiston, NY 14092

Phone: (716) 754-8926

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www.hannapodiatry.com

Welcome, and thank you for choosing our office for your podiatric needs. Enclosed is our new patient packet for you to complete and bring to your appointment.

Please **ARRIVE 15 MINUTES EARLY** to your appointment for check-in processing and remember to bring the following to your appointment:

- **New patient paperwork completed and signed**
- **Driver's License / ID**
- **Insurance Card (s)**
- **Updated Medication List**
- **Referral if your insurance requires one**
- **Xray or testing results**

We do ask if you are unable to keep your appointment for any reason you kindly give us 24 hours notice so that we may use the time for another patient.

If we are seeing you for heel pain, bunions, tendinitis, muscle strains, or orthopedic problems, please wear shoes that you wear most often to the appointment. Please also remove nail polish prior to your visit.

Should you have any questions at all please do not hesitate to contact us.

We look forward to meeting you at your appointment,
and please remember to **ARRIVE 15 MINUTES EARLY for check in.**

Sincerely,

Dr. Hanna and Office Staff
Enc.

PATIENT INFORMATION

In order to serve you properly, we need the following information. Please fill out to the best of your ability. Incorrect information may be dangerous to your health. Please print. All information will be confidential.

Patient Name _____ Date _____
First Middle Initial Last Age _____
Social Security Number _____ Male Female Birth Date _____
Home Phone _____ Cell Phone _____ Work Phone _____
Email Address _____
Address _____ City _____ State _____ Zip _____
Check Appropriate Box: Minor Single Married Divorced Widowed
Patient's/Parent's Employer _____
Spouse/Parent's Name _____ Employer _____
Person to contact in case of emergency _____ Phone _____
Primary Doctor _____ Phone _____
Who may we thank for referring you? _____ Phone _____

PHARMACY INFORMATION

Pharmacy Name _____
Address _____ Phone _____

INSURANCE INFORMATION/RESPONSIBLE PARTY

Name of Insured _____ Relationship to Patient _____
Birthdate _____ Social Security Number _____ Phone _____
Name of Employer _____ Insurance Name _____
Insurance ID _____ Group # _____ Union # _____
Copay/Deductible _____

Do you have additional insurance? Yes No

Name of Insured _____ Relationship to Patient _____
Birthdate _____ Social Security Number _____ Phone _____
Name of Employer _____ Insurance Name _____
Insurance ID _____ Group # _____ Union # _____

AUTHORIZATION & RELEASE

I authorize release of any information concerning my (or my child's) health care, advice, and treatment provided for the purpose of evaluation and administering claims for insurance benefits. I also hereby authorize payment of insurance benefits otherwise payable to me directly to the doctor.

X _____

Signature of patient (or parent if minor)

Date

(please complete both sides)

Please describe your current foot problem _____

Was the problem the result of an accident or event? Please explain _____

Date problem began _____ First visit to a doctor for the problem? Yes No

Previous X-Rays? Yes No Previous treatment? _____

Shoe size _____ Height _____ Weight _____

How much of you day is spent on your feet? (circle one) 10% 30% 50% 70% 90% 100%

List any sports you participate in _____

Use of alcohol: Never Rarely Moderate Daily Previously, not in past _____ years

Use of tobacco: Never Previously, not in past _____ years Current _____ (#) packs per day

Previous hospitalizations/surgeries/serious illness	When?
_____	_____
_____	_____
_____	_____
_____	_____

Medications (include non-prescription) _____

Family Medical History	Medical Diseases	If deceased, cause of death
Father	_____	_____
	_____	_____
Mother	_____	_____
	_____	_____
Brothers & Sisters	_____	_____
	_____	_____

HEALTH HISTORY

Please indicate any personal history below to the best of your ability.

Constitutional Symptoms

Good general health Yes No
 Recent weight change Yes No
 Fever Yes No
 Fatigue Yes No
 Headache Yes No

Eyes

Eye disease or injury Yes No
 Wear glasses/contact lenses Yes No
 Blurred or double vision Yes No

Ears/Nose/Mouth/Throat

Hearing loss or ringing Yes No
 Earaches or drainage Yes No
 Chronic sinus problems/rhinitis Yes No
 Nose bleeds Yes No
 Mouth sores Yes No
 Sore throat or voice change Yes No

Cardiovascular

Heart trouble Yes No
 Chest pain or angina pectoris . Yes No
 Palpitations Yes No
 Shortness of breath with walking or lying flat Yes No
 Swelling: feet, ankles, hands Yes No
 Mitral Valve Prolapse Yes No

Respiratory

Persistent cough or throat clearing not associated with a known illness (lasting more than 3 weeks) Yes No
 Spitting up blood Yes No
 Shortness of breath Yes No
 Wheezing Yes No

Gastrointestinal

Loss of appetite Yes No
 Change in bowel movements .. Yes No
 Nausea or vomiting Yes No
 Frequent diarrhea Yes No
 Painful bowel movements or constipation Yes No
 Rectal bleeding/blood in stool.. Yes No
 Abdominal pain Yes No

Genitourinary

Frequent urination Yes No
 Burning or painful urination Yes No
 Blood in urine Yes No
 Change in force of strain when urinating Yes No
 Incontinence or dribbling Yes No
 Kidney stones Yes No

Musculoskeletal

Joint pain Yes No
 Joint stiffness or swelling Yes No
 Weakness of muscles or joints .. Yes No
 Muscle pain or cramps Yes No
 Back pain Yes No
 Cold extremities Yes No
 Difficulty in walking Yes No

Integumentary (skin, breast)

Rash or itching Yes No
 Change in skin color Yes No
 Change in hair or nails Yes No
 Varicose veins Yes No

Neurological

Frequent/recurring headaches . Yes No
 Light headed or dizzy Yes No
 Convulsions or seizures Yes No
 Numbness/tinging sensations .. Yes No
 Tremors Yes No
 Paralysis Yes No
 Head injury Yes No

Psychiatric

Memory loss Yes No
 Nervousness Yes No
 Depression Yes No
 Insomnia Yes No

Endocrine

Glandular hormone problems... Yes No
 Excessive thirst or urination Yes No
 Heat or cold intolerance Yes No
 Skin becoming drier Yes No
 Change in hat or glove size Yes No
 Diabetes Yes No

Hematologic/Lymphatic

Slow to heal after cuts Yes No
 Bleeding or bruising tendency .. Yes No
 Anemia Yes No
 Phlebitis Yes No
 Past transfusion Yes No

Allergic/Immunologic

History of skin reaction or other adverse reaction to:
 Penicillin or other antibiotics Yes No
 Morphine, Demerol, other narcotics Yes No
 Novocain or other anesthetics . Yes No
 Aspirin or other pain remedies . Yes No
 Tetanus antitoxin/other serums Yes No
 Iodine, Merthiolate, or Other antiseptic Yes No

Other drugs/medications:

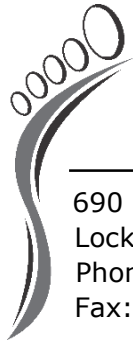
Known food allergies:

Environmental allergies:

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform Dr. Hanna's office of any changes in my medical status. I also authorize the healthcare staff to perform the necessary services that I may need.

Signature of Patient (or Guardian)

Date



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Financial Policy

We are committed to providing you with the best possible care. In order to achieve our goal, we need your assistance and your understanding of our financial policy.

We will submit claims for all insurance companies that we participate with, however we *must* have an assignment of benefits form with your signature on file. Payment for deductibles, co-payments, non-covered services, and supplies is due at the time of service. We accept cash, check, and all major credit cards.

Prompt payment allows us to control costs. Outstanding accounts cost both of us time and money; therefore, we appreciate your timely payments to keep costs down.

Each month you will receive a monthly statement which is due and payable within 30 days. If your payment is late, or if you have not previously made financial arrangements, then we will mail a reminder notice. If you are experiencing a set of circumstances beyond your control, please contact us immediately and we will be happy to make special arrangements.

Balances older than 60 days are subject to a finance charge of 1 ½% per month or an APR of 18%. All patients refusing to remit payments after 60 days of notice without financial arrangements in writing will force us to limit their future credit until the previous balance is paid in full. **All** balances over 90 days will be turned over to a collection company and a \$20 collection charge will be added to the account.

Returned checks are subject to a \$25 fee. Charges may also be made for broken or cancelled appointments without **24 hours** advance notice in the amount of \$25. Any co-payments required by your insurance company **must be paid at the time of service**. Any bills sent to collect on a co-payment will be subject to a \$5 charge *each* time a bill is sent.

It should be mentioned that your insurance coverage is an agreement between you and your insurer. It is your responsibility to remit payment for charges not covered by your insurer.

Our practice firmly believes that a good doctor/patient relationship is based upon understanding and open communications. We will make every effort possible to clarify any misunderstanding and hopefully avoid any disagreement over payment for professional services. If you have any questions concerning our policy or need any further assistance, please contact us immediately.

I certify that I have read and understand the above policy:

Print name: _____

Signature: _____ Date: _____

James R. Hanna, DPM, PC

PATIENT HIPAA ACKNOWLEDGMENT AND APPOINTMENT REMINDER AUTHORIZATION FORM

PATIENT NAME: _____ DOB: _____

Notice of Privacy Practices

I acknowledge that I have received the practice's Notice of Privacy Practices, which describes the ways in which the practice may use and disclose my healthcare information for its treatment, payment, healthcare operations and other described and permitted uses and disclosures, I understand that I may contact the Privacy Officer designated on the notice if I have a question or complaint. I understand that this information may be disclosed electronically by the Provider and/or the Provider's business associates. To the extent permitted by law, I consent to the use and disclosure of my information for the purposes described in the practice's Notice of Privacy Practices. I understand that this authorization will expire on LIFETIME unless date otherwise stated.

PERSONS / ORGANIZATIONS YOU AUTHORIZE JAMES R. HANNA, DPM, PC TO RELEASE INFORMATION TO. Specific description of information to be used or disclosed includes the following: OFFICE NOTES, TEST RESULTS, MEDICATIONS, APPOINTMENTS & BILLING & CLAIM RECORDS. For LIFETIME, unless otherwise stated.

PRIMARY CARE DOCTOR: _____ NAME OF OTHER MEDICAL DOCTORS: _____

NAME OF INDIVIDUAL: _____ RELATIONSHIP: _____ PHONE NUMBER: _____

NAME OF INDIVIDUAL: _____ RELATIONSHIP: _____ PHONE NUMBER: _____

PLEASE ANSWER THESE QUESTIONS: Does the staff of James R. Hanna, DPM, PC have your permission to communicate information regarding medications and/or appointments relating to the above patient by leaving a message on:

HOME ANSWERING MACHINE: YES NO Number: _____

WITH ANOTHER PERSON: YES NO Number: _____

CELL PHONE VOICE MAIL: YES NO Number: _____

MOBILE TEXT: YES NO Number: _____

SEND VIA EMAIL/PORTAL: YES NO Email address: _____

(The practice does not charge for this service, but standard text messaging rates may apply as provided in your wireless plan (contact your carrier for pricing plans and details))

XX _____ SIGNATURE OF PATIENT OR PATIENT'S REPRESENTATIVE / LEGAL GUARDIAN

_____ DATE