James R. Hanna, DPM, PC
Board Certified, American Board of Podiatric Surgery
Diplomate, American Board of Foot and Ankle Surgery
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690 Davison Road
Lockport, NY 14094
Phone: (716) 433-8711
Fax: (716) 433-8705
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 – please call the facility where you had xrays taken and have them fax results to our office at 716-433-8705.

If you are unable to keep your appointment for any reason please call us within 24 hours notice so that we may use the time for another patient.

Charges may be made for appointments that are not kept, no showed, or canceled without 24 hours advance notice in the amount of **$50.00**.

If you are more than 15 minutes late to your scheduled appointment, your appointment may need to be rescheduled.

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 and compression stockings prior to your visit.

ONLY THE PATIENT WHO HAS THE APPOINTMENT IS PERMITTED IN THE BUILDING. FAMILY MEMBERS MAY WAIT IN THE CAR.

Should you have any questions at all please do not hesitate to contact us. We look forward to meeting you at your appointment.

Sincerely,

Dr. Hanna and Office Staff

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	_____	_____
	_____	_____

Signature of patient (or Guardian)_____ Date_____

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

HIPAA ACKNOWLEDGMENT / PRESCRIPTION HISTORY / APPOINTMENT REMINDER AUTHORIZATION FORM

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:_____

MEDICATION HISTORY: YOU AUTHORIZE JAMES R. HANNA, DPM, PC TO RETRIEVE INFORMATION FROM YOUR PHARMACY THROUGH SURESCRIPTS.

We are affiliated with Surescripts in which we will obtain your Medication History as part of the reconciliation process at the point of care. To provide this service, Surescripts securely connects to a patient's medication history data stored in the databases of community pharmacies and pharmacy benefit managers. Surescripts then presents that data to healthcare providers through their certified software vendor. Surescripts requires that healthcare providers obtain all necessary patient consents, including those required by all applicable federal and state laws and regulations, prior to electronically accessing a patient's medication history. Surescripts also permits patients to opt out of participating in the Medication History service; requests to opt out should be directed to the patient's healthcare provider.

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:_____

CELL PHONE VOICE MAIL: YES NO Number:_____

CELL PHONE 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)

PATIENT NAME: (PRINT)_____

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