Dr. Jesse H. Bradley

Patient Name____

Patient Information

First Name ____________________

Last Name ____________________

Middle Initial ____________________

Address ____________________

City/State/Zip ____________________

Cell Phone ____________________ Home Phone ____________________

Email ____________________

Male or Female? ____________________

Social Security# ____________________

Birth Date & Age ____________________ Marital Status ____________________

Employer/School ____________________

Address ____________________

Occupation ____________________

In Case of Emergency, Contact

First Name ____________________

Last Name ____________________

Cell Phone ____________________ Work Phone ____________________

Email ____________________

Relationship To ____________________

Spouse Information, If Applicable

First Name ____________________

Last Name ____________________

Cell Phone ____________________ Work Phone ____________________

Email ____________________

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Patient Name____

Podiatric History

Chief Complaint ____

Last Podiatrist ____

Diabetic? (Y/N) ________________________ Smoker? (Y/N) ______________________

Please check which foot problems you have now or have had in the past…

- ☐ Ankle pain
- ☐ Athlete's Foot
- ☐ Bunions
- ☐ Corn and Calluses
- ☐ Cramps or numbness in foot or leg
- ☐ Flat feet
- ☐ Heel pain
- ☐ Ingrown toenails
- ☐ Plantar warts
- ☐ Swelling in ankles or feet

Medical History

Please check all that apply if you have or had any of the following…

- ☐ AIDS/HIV
- ☐ Allergies to anesthetics
- ☐ Allergies to medicines or drugs
- ☐ Anemia
- ☐ Angina
- ☐ Arthritis
- ☐ Artificial heart valves or joints
- ☐ Asthma
- ☐ Back problems
- ☐ Bleeding disorders
- ☐ Cancer
- ☐ Chemical dependency
- ☐ Chest pain

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- ☐ Chronic diarrhea
- ☐ Circulatory problems
- ☐ Diabetes
- ☐ Ear problems
- ☐ Epilepsy
- ☐ Fainting
- ☐ Foot or leg cramps
- ☐ Gout
- ☐ Headaches
- ☐ Heart disease
- ☐ Hemophilia
- ☐ Hepatitis or jaundice
- ☐ High blood pressure
- ☐ Kidney problems
- ☐ Liver disease
- ☐ Low blood pressure
- ☐ Neuropathy
- ☐ Phlebitis
- ☐ Psychiatric care
- ☐ Radiation and/or chemotherapy treatment
- ☐ Rash
- ☐ Respiratory disease
- ☐ Rheumatic fever
- ☐ Shortness of breath
- ☐ Sinus problems
- ☐ Special diet
- ☐ Stroke
- ☐ Swelling in ankles and/or feet
- ☐ Plantar warts
- ☐ Swelling in ankles or feet
- ☐ Swollen neck glands

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- ☐ Tired feet
- ☐ Tuberculosis
- ☐ Ulcers
- ☐ Varicose veins
- ☐ Venereal disease (STD)
- ☐ Weight loss, unexplained

List Any Surgeries ____
____
____
____

Other Hospitalization ____
____
____

Name of Family Physician ____

Date Last Seen ____

Currently Under a Doctor's Care? If Yes, Explain ____
____
____
____
____
____

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Patient Name____

Medications

Pharmacy Name ____________________

Pharmacy Phone ____________________

Contraceptives? (Y/N) ____________ If Taking, Name ____________

List Medications ____________________

List Supplements ____________________

List Allergies ____________________

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Patient Name____

Insurance Assignment and Release

I certify that I have insurance coverage with ____ and assign directly to **Dr. Jesse Bradley, DPM** all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

MEDICARE/MEDIGAP AUTHORIZATION

I request that payment of authorized Medicare benefits and, if applicable, Medigap benefits, be made either to me or on my behalf to **Bradley Foot Care** for any services furnished to me by that provider.

To the extent permitted by law, I authorize any holder of medical or other information about me to release to the Centers for Medicare and Medicaid Services, my Medigap insurer, and their agents any information needed to determine these benefits or benefits for related services.

____ ____________________________
Signature of Patient, Parent, Guardian, or Representative Date

____ ____________________________
Please print name of Patient, Parent, Guardian, or Representative Relationship to Patient

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Dr. Jesse H. Bradley

Patient Name____

Treatment Consent

I hereby give my consent and give my permission to the doctor (and the doctor's assistants or designated replacement) to administer and perform such procedures upon me as the doctor deems necessary.

____ ___________________________________

Signature of Patient, Parent, Guardian, or Representative Date

____ __________________________________

Please print name of Patient, Parent, Guardian, or Representative Relationship to Patient

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Patient Name_______________________________________

PATIENT NAME ____

PATIENT INFORMATION

Height __________ Weight ____________ Shoe Size ______________

Do you smoke or use tobacco (Y/N) _________ If yes, how long? _______________

Have you ever smoked cigarettes or used tobacco products in the past? _________

SIGNATURE______________________________ DATE ______________________

HEALTH INFORMATION PRIVACY

I give my health care provider written permission to share my healthy information with my family members, friends, or others involved in my care or payment for my care.

SIGNATURE______________________________ DATE ______________________

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY

I have reviewed and/or been offered to review a copy of this office HIPPA OMNIBUS NOTICE OF PRIVACY PRACTICES.

SIGNATURE______________________________ DATE ______________________

Dr. Jesse H. Bradley

Patient Name_______________________________________

I, ____ *(name of patient)*, hereby authorize

representatives of __________________________ *(name of facility)*, my physician(s) or other designated person(s) to photograph, videotape or use other appropriate electronic media recording of me (hereafter collectively referred to as photographs) while under the care of the above named facility with the following restrictions: *(write none if no restrictions—do not leave blank)*____

____

I understand that these photographs of me are to document my medical condition, to be used in research, or for clinical educational purposes. I further understand that, based on the reason for the photographs, the may be maintained as a permanent part of my medical record, release of which shall be in accordance with applicable medical information regulations and laws.

I release and hold the facility, its employees, agents, and affiliates and my physician or his/her designees harmless from any and all liability, claims, demands or causes of actions whatsoever arising from and in any way associated with taking, displaying or use of these photographs.

This release and indemnification shall be as broad and inclusive as is permitted by the State of _______________________________ *(name of state in which facility is located)*. If any portion is held invalid, the balance shall continue to be in full force and effect.

I certify that I have read, understand and agree to the terms of this consent and release.

____ _______________________ __________________

Patient's Signature or Authorized Representative Date Time

____ ____

Relationship to Patient Interpreter (if utilized)

____ ____

Witness Signature If Telephone Consent, Second Witness Signature

Authorization for Imaged Media, or Recorded
On Other Electronic Media for Patient Care Purposes *(Patient Label)*
RM-1703 (Rev 06/06, 03/11)
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