

676 Shoup Ave. West, Suite 12
Twin Falls, ID 83301
208-733-0436
Fax 208-733-0438



2303 Parke Ave Unit 1 Suite 1
Burley, Idaho 833301
208-678-2727
Fax 208-678-1477

WELCOME TO OUR OFFICE

Patient _____ Date ____/____/____
Home Address _____ Apt/PO Box _____
City _____ State _____ Zip _____
Home Phone # (____) _____ Fax Phone # (____) _____
Work Phone # (____) _____ Ext _____ Cell Phone # (____) _____
E-Mail _____ Social Security # _____ - _____ - _____
Dr. Lic # _____ Date Of Birth ____/____/____ Age ____ Sex Male ____ Female ____
Marital Status: Single ____ Married ____ Widowed ____ Separated ____ Divorced ____
Spouse's/ Guardian's Name _____
Spouse's Date of Birth ____/____/____ Social Security # _____ - _____ - _____

Patient Employer
Employer _____ Occupation _____
Employer Address _____
City _____ State _____ Zip _____
Employer Phone# (____) _____ Contact Person _____

Spouse Employer
Employer _____ Occupation _____
Employer Address _____
City _____ State _____ Zip _____
Employer Phone# (____) _____ Contact Person _____

Insurance Information
Who is responsible for this account? Patient ____ Other _____
Relationship to Patient? _____
Primary Insurance Company _____
Group/ ID # _____ Plan # _____

Are you covered by other insurance? Yes ____ No ____
Subscriber's Name _____
Subscriber's Date of Birth ____/____/____ Subscriber's SS# _____ - _____ - _____

Primary Care Physician _____ Referred by: _____



Cory A. Pilling, DPM
Podiatric Medicine & Surgery

CONFIDENTIAL OFFICE MEDICAL RECORD

Name _____ Date _____

Chief Complaint

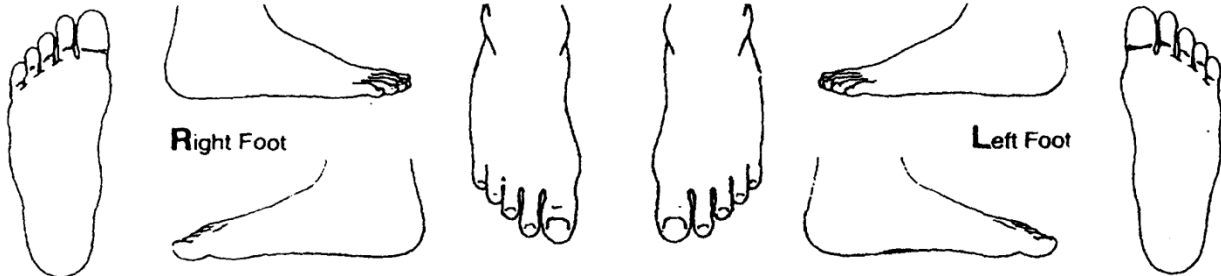
Age _____

What is your main foot problem today? _____

Do you have any other foot problems that need attention? _____

History of Present Illness

Mark on the diagram below the areas where each problem is located.



When did your main problem begin? _____ [] Days [] Weeks [] Months [] Years ago.

Is the pain: [] Burning, [] Throbbing, [] Sharp, [] Dull, [] Aching, [] Tingling, [] Numbness, [] Itching, [] Other _____

How severe is your pain? 0 1 2 3 4 5 6 7 8 9 10
(No Pain) **PLEASE CIRCLE** (Extreme pain)

Is the pain worse after rest or after activity? [] Rest [] Activity

What causes the problem or makes it worse? _____

Was it caused by an injury? [] No [] Yes (if yes, explain)

What previous treatments have been used?:

Self: _____

Professional: _____

Past/Family/Social History

Name _____

Past History

Injuries

- No injuries of consequence
- List serious injuries and approximate age:

Major Past Illnesses

- No serious past illnesses
- List serious illness and approximate age:

Surgeries or Hospitalizations

- None
- List any surgeries or hospitalizations:

Had surgery/ hospitalization for:	On date of:	With complications:
_____	_____	_____
_____	_____	_____
_____	_____	_____

Do you have vascular grafts? Yes No Where? _____

Do you have joint implants? Yes No Where? _____

Do you have replacement heart valves? Yes No Where? _____

Are you under active chemotherapy? Yes No Where? _____

FAMILY HISTORY

Is there a family history of any of the following: *(Please indicate parent affected)*

<input type="checkbox"/> Diabetes	<input type="checkbox"/> Mother <input type="checkbox"/> Father	<input type="checkbox"/> Gout	<input type="checkbox"/> Mother <input type="checkbox"/> Father
<input type="checkbox"/> Birth Defects	<input type="checkbox"/> Mother <input type="checkbox"/> Father	<input type="checkbox"/> Arthritis	<input type="checkbox"/> Mother <input type="checkbox"/> Father
<input type="checkbox"/> Heart Attack	<input type="checkbox"/> Mother <input type="checkbox"/> Father	<input type="checkbox"/> Foot Problems	<input type="checkbox"/> Mother <input type="checkbox"/> Father
<input type="checkbox"/> Cancer	<input type="checkbox"/> Mother <input type="checkbox"/> Father	<input type="checkbox"/> Stroke	<input type="checkbox"/> Mother <input type="checkbox"/> Father
<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Mother <input type="checkbox"/> Father	<input type="checkbox"/> Other	<input type="checkbox"/> Mother <input type="checkbox"/> Father

Mother	<input type="checkbox"/> Alive	<input type="checkbox"/> Died	Age of Death _____	Cause of Death _____
Father	<input type="checkbox"/> Alive	<input type="checkbox"/> Died	Age of Death _____	Cause of Death _____

Social History

Occupation: _____

Activity Level: Sedentary Moderately Active Athletic

Do you smoke now? Yes No Packs/day _____ Years _____

Did you ever smoke? Yes No Packs/day _____ Years _____

Alcoholic beverages? None Rarely Moderately Daily Quit

Review of Systems

PATIENT Please place an "X" in the boxes that apply.

<p><u>Constitutional</u></p> <ul style="list-style-type: none"> <input type="checkbox"/> Fatigue <input type="checkbox"/> Weight Loss - 15 lbs. <input type="checkbox"/> Weight Gain + 15 lbs. <input type="checkbox"/> Fever <input type="checkbox"/> Chills <input type="checkbox"/> Malaise 	<p><u>Neurological</u></p> <ul style="list-style-type: none"> <input type="checkbox"/> Stroke <input type="checkbox"/> Headaches <input type="checkbox"/> Seizures <input type="checkbox"/> Memory Loss <input type="checkbox"/> Alzheimer's <input type="checkbox"/> Parkinson's Disease <input type="checkbox"/> Tremor/Hand Shake <input type="checkbox"/> Fainting <input type="checkbox"/> Loss of Balance <input type="checkbox"/> Burning / Tingling to Legs / Feet <input type="checkbox"/> Sciatica <input type="checkbox"/> Multiple Sclerosis <input type="checkbox"/> Polio <input type="checkbox"/> Spine Disease <input type="checkbox"/> Other _____ 	<p><u>Cardiovascular</u></p> <ul style="list-style-type: none"> <input type="checkbox"/> Chest Pain/Angina <input type="checkbox"/> Heart Attack <input type="checkbox"/> Rapid Heart Beat <input type="checkbox"/> Palpitations <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Open Heart Surgery <input type="checkbox"/> Angioplasty <input type="checkbox"/> High Cholesterol <input type="checkbox"/> Feet Swell <input type="checkbox"/> Irregular Heart Beat <input type="checkbox"/> Pacemaker <input type="checkbox"/> Mitral Valve Prolapse <input type="checkbox"/> Artificial Heart Valve <input type="checkbox"/> Heart Murmurs <input type="checkbox"/> Rheumatic Fever <input type="checkbox"/> Circulation Disorders <input type="checkbox"/> Blocked Arteries <input type="checkbox"/> Varicose Veins <input type="checkbox"/> Leg Pain on Walking <input type="checkbox"/> Leg Pain at Rest <input type="checkbox"/> Cold Numb Feet <input type="checkbox"/> Night Pain or Cramps <input type="checkbox"/> Blood Clot in Legs <input type="checkbox"/> Phlebitis <input type="checkbox"/> Congestive Heart Failure <input type="checkbox"/> Other _____
<p><u>Gastrointestinal</u></p> <ul style="list-style-type: none"> <input type="checkbox"/> Nausea <input type="checkbox"/> Vomiting <input type="checkbox"/> Diarrhea <input type="checkbox"/> Constipation <input type="checkbox"/> Ulcers <input type="checkbox"/> Poor Appetite <input type="checkbox"/> Excessive Thirst <input type="checkbox"/> Eating Disorders <input type="checkbox"/> Abdominal Pain <input type="checkbox"/> Difficulty Swallowing <input type="checkbox"/> Black / Bloody Stool <input type="checkbox"/> Liver Problems <input type="checkbox"/> Hepatitis A <input type="checkbox"/> Hepatitis B <input type="checkbox"/> Hepatitis C <input type="checkbox"/> Gallbladder Problems <input type="checkbox"/> Hiatal Hernia <input type="checkbox"/> Cirrhosis <input type="checkbox"/> Jaundice <input type="checkbox"/> Irritable Bowel Syndrome <input type="checkbox"/> Crohn's disease/Colitis <input type="checkbox"/> Pancreatic Disease <input type="checkbox"/> Heart Burn/Reflux Esophagitis <input type="checkbox"/> Colon Polyps <input type="checkbox"/> Hemorrhoids <input type="checkbox"/> Rectal Fissure <input type="checkbox"/> Other _____ 	<p><u>Ears / Nose / Throat</u></p> <ul style="list-style-type: none"> <input type="checkbox"/> Hearing Loss <input type="checkbox"/> Tinnitus (Ringing in Ears) <input type="checkbox"/> Ear Infections <input type="checkbox"/> Ear Pain <input type="checkbox"/> Dizziness <input type="checkbox"/> Nose Bleeding <input type="checkbox"/> Nose Discharge <input type="checkbox"/> Sinus Infections <input type="checkbox"/> Loss of Smell <input type="checkbox"/> Sinusitis <input type="checkbox"/> Difficult Swallowing <input type="checkbox"/> Sore Gums <input type="checkbox"/> Sore Throat <input type="checkbox"/> Hoarseness <input type="checkbox"/> Neck Masses <input type="checkbox"/> Dental Problems <input type="checkbox"/> Breathing Difficulty <input type="checkbox"/> Speech Difficulty <input type="checkbox"/> Other _____ 	
<p><u>Genitourinary</u></p> <ul style="list-style-type: none"> <input type="checkbox"/> Kidney Disease <input type="checkbox"/> Bladder Problem <input type="checkbox"/> Renal Failure <input type="checkbox"/> Kidney Stones <input type="checkbox"/> Painful Urination <input type="checkbox"/> Frequent Urination <input type="checkbox"/> Scanty Urination <input type="checkbox"/> Blood in Urine <input type="checkbox"/> Discolored Urine <input type="checkbox"/> Urinary Tract Infection <p style="text-align: center;"><u>Female</u></p> <ul style="list-style-type: none"> <input type="checkbox"/> Sexually Transmitted Disease <input type="checkbox"/> Breast Cancer <input type="checkbox"/> Ovarian Cancer <input type="checkbox"/> Oral Contraceptives <p style="text-align: center;"><u>Male</u></p> <ul style="list-style-type: none"> <input type="checkbox"/> Sexually Transmitted Disease <input type="checkbox"/> Prostate Cancer 	<p><u>Eyes</u></p> <ul style="list-style-type: none"> <input type="checkbox"/> Blindness <input type="checkbox"/> Glaucoma <input type="checkbox"/> Retinal Problems <input type="checkbox"/> Cataracts <input type="checkbox"/> Glasses / Contacts <input type="checkbox"/> Impaired Sight <input type="checkbox"/> Macular Degeneration <input type="checkbox"/> Other _____ 	<p><u>Integumentary</u></p> <ul style="list-style-type: none"> <input type="checkbox"/> Psoriasis <input type="checkbox"/> Rash <input type="checkbox"/> Itching <input type="checkbox"/> Athlete's Foot <input type="checkbox"/> Skin Ulcerations <input type="checkbox"/> Skin Cancer <input type="checkbox"/> Deformed Nail <input type="checkbox"/> Dry, Scaly Skin <input type="checkbox"/> Warts <input type="checkbox"/> Infection Skin <input type="checkbox"/> Eczema <input type="checkbox"/> Color Change Mole/Wart <input type="checkbox"/> Hives <input type="checkbox"/> Shingles <input type="checkbox"/> Thick Scar or Keloids <input type="checkbox"/> Recent Hair Loss <input type="checkbox"/> Other _____

PAYMENT POLICY

The filing of insurance claims is a courtesy we extend to our patients. We are happy to assist you in billing most insurance companies. However, we must emphasize that your insurance is a contract between you and your insurance company. We are not party to that contract.

Many of the services provided in this office are covered and paid by your insurance company. In cases where the service has not been paid, you will be personally responsible for the balance. If the patient is a minor, the person bringing the minor to the office for treatment is responsible for payment of the bill.

Payments for services are due at the time service is rendered. We accept cash, checks (including post dated checks), and money orders. We also accept Visa and MasterCard. To assist you in making payments if special circumstances arise, we would be happy to arrange an automatic debit payment schedule to facilitate regular agreed upon payments.

Account balances:

0-30 days---no interest

31-60 days---interest accrues

90 days & over will be turned over to CFS, LLC

Signature: _____ Date: _____

SUMMARY OF NOTICE OF PRIVACY PRACTICES

This summary is provided to assist you in understanding the attached Notice of Privacy Practices

The attached Notice of Privacy Practices contains a detailed description of how our office will protect your health information, your rights as a patient and our common practices in dealing with patient health information. Please refer to that Notice for further information.

Uses and Disclosures of Health Information. We will use and disclose your health information in order to treat you or to assist other health care providers in treating you. We will also use and disclose your health information in order to obtain payment for our services or to allow insurance companies to process insurance claims for services rendered to you by us or other health care providers. Finally, we may disclose your health information for certain limited operational activities such as quality assessment, licensing, accreditation, and training of students.

Uses and Disclosures Based on Your Authorization. Except as stated in more detail in the notice of Privacy Practices, we will not use or disclose your health information without your written authorization.

Uses and Disclosures Not Requiring Your Authorization. In the following circumstances, we may disclose your health information without your written authorization:

- To family members or close friends who are involved in your health care;
- For certain limited research purposes;
- For purposes of public health and

safety;

- To Government agencies for purposes of their audits, investigations and other oversight activities;
- To government authorities to prevent child abuse or domestic violence;
- To the FDA to report product defects or incidents;
- To law enforcement authorities to protect public safety or to assist in apprehending criminal offenders;
- When required by court orders, search warrants, subpoenas and as otherwise required by the Law.

Patient Rights. As our patient, you have the following rights:

- To have access to and/or a copy of your health information;
- To receive an accounting of certain disclosures we have made of your health information;
- To request restrictions as to how your health information is used or disclosed;
- To request that we communicate with you in confidence;
- To request that we amend your health information;
- To receive notice of our privacy practices.

If you have a question, concern or complaint regarding our privacy practices, please refer to the attached Notice of Privacy Practices for the person or persons whom you may contact.

**ACKNOWLEDGEMENT OF RECEIPT
OF
NOTICE OF PRIVACY PRACTICES**

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

Patient Name (Please Print)

Date

Parent or Authorized Representative (if applicable)

Signature