WE DO NOT ACCEPT WORK COMP, LEGAL, OR 3RD PARTY LIABILITY CASES

Is the patient being seen today for an on the job injury or third party liability injury? No **Yes ==> If there is any potential of a work related injury you need to follow the proper protocol for reporting this to your employer. They will refer you to an approved work comp physician.**

Please provide any details regarding any injury or possible injury.

_____
_____
_____
_____

Who may we thank for referring you?
_____

This office utilizes e-prescribing. We must have your pharmacy name and phone number
_____

Please provide a valid email address for purposes of office contact only. Your email will not be sold or distributed
_____

In case of emergency, who should be notified? _____
Phone_____
What relationship to you are they? _____

Patient name: _____ **DOB** _____

Gender Male Female **Patient SS #** _____
Marital Status Single (never married) / Married / Separated/ Divorced/ Widowed/ Partner

Address _____

City _____ **State** _____ **Zip** _____

Home phone # _____**Cell phone #** _____**Work #** _____

If the patient is a minor child is there a court ordered custody agreement governing health insurance?
yes no

If the patient is a minor child who do they live with ? _____
Is the patient a full time student?
No Yes ==> If yes, where? _____

Is the patient actively employed?
No Yes ==> If yes, where?_____ Work # <<PWorkPhone>>

Who is the responsible party? (Self Spouse Parent Guardian Other)
If other than "self" please complete:

Name_____SS #_____DOB _____

Address _____
City_____State_____Zip_____

Does the patient have medical insurance, including Medicare or Medicaid? No Yes
If yes complete below

Primary Ins Company _____
Primary Insured's name_____
Relationship to patient _____
Is the primary insured actively employed? yes no
Employer _____
Insured's DOB _____ **Insured SS #** _____

Primary Ins Company _____
Primary Insured's name_____
Relationship to patient _____
Is the primary insured actively employed? yes no
Employer _____
Insured's DOB _____ **Insured SS #** _____

Dr. Brian Shwer & Dr. Robert Appling

3051 KIRBY WHITTEN PKWY #5
BARTLETT, TN 38134
(901) 383-7272

564 EAST GOODMAN ROAD
SOUTHAVEN, MS 38671
(662)349-7333

NOTICE OF PRIVACY PRACTICES PATIENT ACKNOWLEDGEMENT

I HAVE RECEIVED THIS PRACTICE'S NOTICE OF PRIVACY PRACTICES WRITTEN IN PLAIN LANGUAGE. THE NOTICE PROVIDES IN DETAIL THE USES AND DISCLOSURES OF MY PROTECTED HEALTH INFORMATION THAT MAY BE MADE BY THIS PRACTICE, MY INDIVIDUAL RIGHTS, HOW I MAY EXERCISE THESE RIGHTS, AND THE PRACTICE'S LEGAL DUTIES WITH RESPECT TO MY INFORMATION.

I UNDERSTAND THAT THIS PRACTICE RESERVES THE RIGHT TO CHANGE THE TERMS OF IT'S NOTICE OF PRIVACY PRACTICES, AND TO MAKE CHANGES REGARDING ALL PROTECTED HEALTH INFORMATION RESIDENT AT, OR CONTROLLED BY, THIS PRACTICE. I UNDERSTAND I CAN OBTAIN THIS PRACTICE'S CURRENT NOTICE OF PRIVACY PRACTICES UPON REQUEST.

I GIVE PERMISSION FOR THE STAFF OF THIS PRACTICE TO LEAVE MESSAGES REGARDING MY APPOINTMENTS, ACCOUNT STATUS ETC ON MY ANSWERING MACHINE/ VOICE MAIL OR WITH PERSONS ANSWERING MY PHONE.

PATIENT NAME : _____ DATE OF BIRTH: _____

SIGNATURE: _____DATE: _____

RELATIONSHIP TO PATIENT IF SIGNED BY A PERSONAL REPRESENTATIVE OF THE PATIENT:

_____

ASSIGNMENT AND RELEASE

I understand that the physician is required by law to bill me for any amount applied to my annual deductible and/or coinsurance, which is based upon the charge determination of the insurance carrier. I understand that I am financially responsible for all charges whether or not paid by insurance. I am aware that delinquent accounts are susceptible to late fees and, if necessary, will be turned to collections and reported to the Credit Bureau. In the event of default I agree to pay all Attorney's fees and Collection's agency fees. I, the undersigned, have insurance coverage with the above noted insurance carrier (if any) and assign directly to Dr. Brian Shwer all medical benefits, if any, otherwise payable to me for services rendered. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions. I request that payment of authorized Medicare benefits (if applicable) be made on my behalf to Dr. Brian Shwer for any services furnished to me. I authorize any holder of medical information about me to release to CMS and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and non-covered services deemed by Medicare to be "patient responsible."

_____

Signature of patient (must be signed by an adult if patient is a minor) Date

MEDICAL INFORMATION
(THIS INFORMATION IS IMPORTANT FOR OUR RECORDS AND YOUR HEALTH)

Reason for your visit today :

_____

_____

How long has it been bothering you? _____
Describe any past problems with your feet and/or ankles and summarize what treatement was performed:

_____

_____

_____

Shoe size _____Current Weight_____Height _____

List any medications including supplements that you are currently taking:

_____

_____

_____

List any medications that you are allergic to and the reaction you have:

_____

_____

_____

Are you allergic to Tape, Adhesive, Iodine, Latex or anesthetics?

_____

List any surgeries that you have had

_____

_____

_____

_____

HEALTH HISTORY
Circle all that you have or have had problems with:

General: Unexplained Weight loss/ gain, Fever, Chronic Fatigue, Anemia, Bruising Easily, Allergies

Eyes: Failing Vision, Eye Infections, Double Vision, Blurry Vision

Cardiovascular: Chest Pain, Dizziness/ Fainting, Palpitations, Swollen Ankles, Leg Pain, Varicose Veins, Circulatory Problems, numbness in feet/ extremities, tingling in feet/ hands

Respiratory: Chronic Cough, Asthma, Shortness of Breath, COPD, other lung disorder

Neurological: Convulsion, Seizure, Tremor (shaking), Muscle Weakness, Numbness, Tingling, Frequent Headaches

Musculoskeletal: Arthritis/ Joint Pain, Back Pain, Muscle Pain

Skin: Rashes/ Hives, Itching, skin disorder, Ulcers, Fissures, Callous, Corn

Psychiatric: Nervousness, Depression, Anxiety, Memory Loss, Trouble Sleeping

Have you had any of these conditions?

High Blood Pressure	Diabetes (IDDM/ NIDDM)	Stroke	Chronic Bronchitis/ COPD
Asthma	Epilepsy	Renal Failure	High Cholesterol
Kidney Problems	Arthritis	Back Pain	Alcoholism
Migraines	Peripheral Vascular Disease		Illegal Drug Use
Hepatitis A	Hepatitis B	Hepatitis C	HIV+
Thyroid Disease	Cancer (type		

Is there a family history (blood relative) of the following:

Heart Disease	Diabetes	Cancer	Stroke	Bleeding Disorder
Arthritis	Gout	Neurological disorder	Circulation Problems in feet or legs	

Do you smoke? yes no **if yes, # of packs/ day _____ for how long_____**

Past smoker? yes no **how much for how long _____ when did you quit**? _____

Do you drink Alcohol? yes no, **if yes**: rarely, 1-2 drinks per week, 2 drinks per day, more than 2 daily

Employment Conditions: not actively employed (retired, disabled, unemployed, homemaker)
sits all day at work
stands and/or walks all day at work

Agreement/ Conditions of Treatment

This is an agreement between Dr. Brian Shwer and myself, summarizing our understanding of the conditions under which I consent to treatment of my foot and/ or ankle condition(s). I understand that Dr. Shwer will use his best skill and judgment to accomplish the desired result, but that Dr. Shwer cannot and does not warrant or guarantee such result; also that his forecast of the length of time involved in therapy and/ or recovery from any treatment including but not limited to surgery, the manner of recovery and the possible complications or untoward results is based upon the usual and average response in cases similar to mine, but that it is not a promise, since healing is an individual process and my result/ response may be different than the usual. I promise full cooperation with Dr. Shwer and his staff in my treatment, whether by surgical or non-surgical means. I understand that if I do not follow the instructions given to me by Dr. Shwer and/ or his staff concerning my care and treatment the outcome of my care and treatment could be put in jeopardy and a bad result may occur. I understand that the above medical information is necessary in order for Dr. Shwer to be able to provide me with medical care in the most safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, I give my permission to ask the respective healthcare provider or agency for that information and I realease them to provide that information for continuation of medical care. I understand that it is imperative that I advise the office immediately of any changes in my health status or medications.

Patient Name _____
Patient/ Guardian Signature _____ Date:_____
Witness _____