





**Your Medical History:** \*\* **Height:**\_\_\_\_\_ **Weight:**\_\_\_\_\_ lbs

→ **ALLERGIES:** Medications:\_\_\_\_\_ Other:\_\_\_\_\_

Anesthesia:\_\_\_\_\_ Foods:\_\_\_\_\_ Tape:\_\_\_\_\_ NONE:\_\_\_\_\_

Have you ever had any of the Following?: (please Circle)

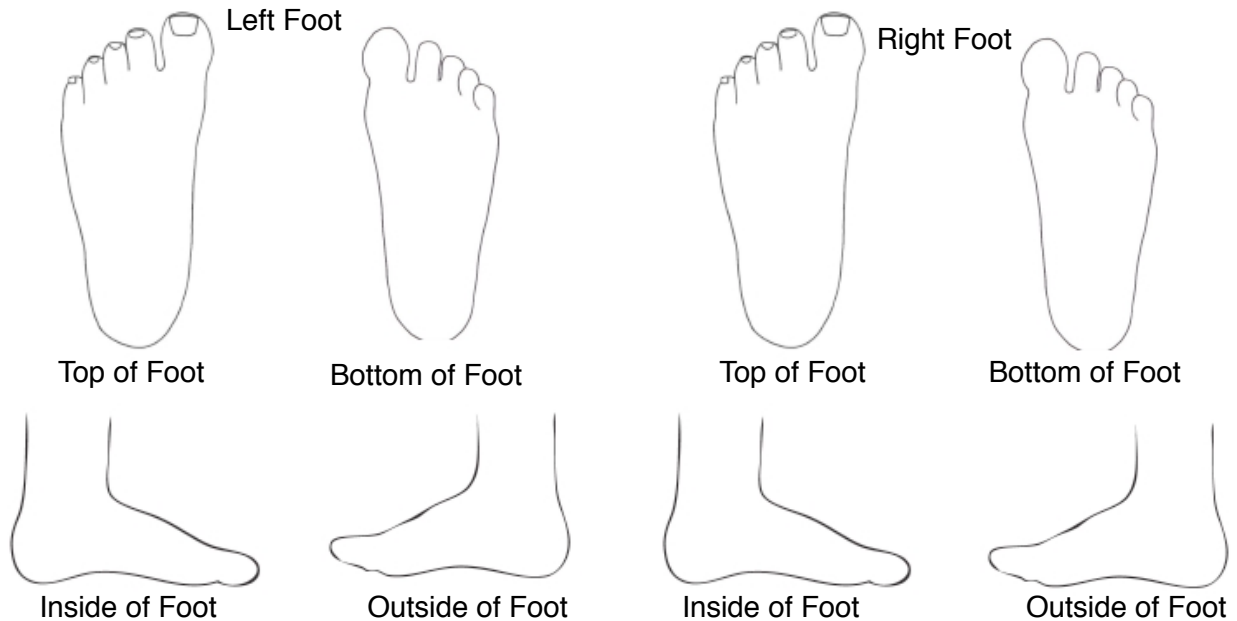
Acid Reflux	Fibromyalgia	Mitral Valve Prolapse		
Anemia	Gout	Neuropathy		
Arthritis	Heart Attack	Open Sores		
Asthma	Heart Disease / Failure	Pneumonia		
Back Trouble	Hepatitis	Rheumatic Fever		
Bladder Infections	HIV / AIDS	Sickle Cell Disease		
Abnormal Bleeding	High Blood Pressure	Skin Disorder		
Blood Clots	High Cholesterol	Sleep Apnea		
Blood Trasfusion	Kidney Disease	Stomach Ulcers		
Bronchitis / Emphysema	Liver Disease	Stroke		
Cancer	Low Blood Pressure	Thyroid Disease		
Diabetes	Migraine Headaches	Tuberculosis		

Other Conditions:\_\_\_\_\_

**CURRENT PROBLEM:**

What Specific Problem brings you into our office today? \_\_\_\_\_

Where is the Pain? (please mark below) How bad is the pain? \_\_\_\_\_





WHITE SANDS  
— PODIATRY —  
FOOT AND ANKLE SURGERY CENTER

TO THE BEST OF MY KNOWLEDGE, I HAVE ANSWERED THE QUESTIONS ON THIS FORM ACCURATELY. I UNDERSTAND THAT PROVIDING INCORRECT INFORMATION CAN BE DANGEROUS TO MY HEALTH. I UNDERSTAND THAT IT IS MY RESPONSIBILITY TO INFORM THE DOCTOR AND OFFICE STAFF OF ANY CHANGES IN MY MEDICAL STATUS.

I, the undersigned assign directly to Sean Hodson, DPM all medical 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 understand that every possible effort will be made to collect outstanding financial responsibilities. I understand that failure to pay outstanding charges will be reported to our collection agency. I understand that this document authorizes treatment and hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions. By signing below, you state that you have read and understand above.

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Print Name of Patient, Parent, or Guardian

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If other than patient, Relationship to Patient

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Signature

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Date



**WHITE SANDS**  
— **PODIATRY** —  
FOOT AND ANKLE SURGERY CENTER

SEAN HODSON, DPM — PHONE: 850-622-1607 — FAX: 888-302-6552

## CONSENT FOR PURPOSES OF TREATMENT, PAYMENT, AND HEALTHCARE OPERATIONS

I consent to the use or disclosure of my protected health information by White Sands Podiatry for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills, or to conduct health care operations of White Sands Podiatry. I understand that diagnosis or treatment of me by Dr. Sean Hodson may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment, or healthcare operations of the practice. White Sands Podiatry is required to agree to the restrictions that I may request. However, if White Sands Podiatry agrees to a restriction request, the restriction is binding on White Sands Podiatry and Dr Sean Hodson.

I have the right to revoke this content, in writing, at any time, except in the extent that Dr Sean Hodson or White Sands Podiatry has taken action in reliance of this consent.

My “protected health information” means health information, including my demographic information, collected from me and created or received by my physician , another health care provider, a health plan, my employer, or a health care clearinghouse. This protected health information relates to my past, present, or future physical or mental health condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have the right to review White Sands Podiatry’s Notice of Privacy Practices prior to signing this document. The notice of privacy practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills, or in the performance of health care operations of White Sands Podiatry. The notice of privacy practices for White Sands Podiatry also describes my rights and White Sands Podiatry’s duties with respect to my protected health information.

White Sands Podiatry reserves the right to change the privacy practices that are described in the notice of privacy practices. I may obtain a revised notice of privacy practices by calling the office and requesting a revised copy be sent by mail or asking for one at the time of my next appointment.

\_\_\_\_\_  
Signature of Patient

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name of Patient