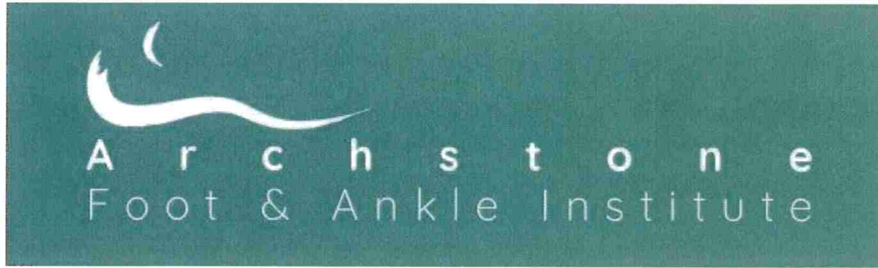

PATIENT INFORMATION UPDATE FORM

Please assist our office in updating your demographic and medical information.

Patient Name: ______________________________ Date of Birth: ____/____/____

PERSONAL INFORMATION

❑ NO CHANGES

1. Name: ______________________________
2. Address:
   Street______________________________
   City__________________State________Zip______
3. Home phone number: ______________________
4. Cell phone number: ______________________
5. Email address: __________________________
6. Preferred contact method: Phone call ___ Email ___
7. Emergency contact: ______________________
   Phone Number: ___________________________
   Relationship: ___________________________

INSURANCE INFORMATION

❑ NO CHANGES

8. Insurance Provider: ______________________
9. Policy Number: ___________________________

MEDICATION LIST

❑ NO CHANGES

10. Name of Patient's Pharmacy: ________________
11. Pharmacy Address: _______________________
12. Pharmacy Telephone:______________________

Medication	Dosage

HEALTH INFORMATION

❑ NO CHANGES

13. Primary Care Physician ____________________
14. Physician Tel. #:__________________________
15. Known Allergies:___________________________
    ❑ I have no allergies
16. Please list any **new** medical conditions that you are currently being treated for:
    ____
    ____
    ____
17. Have you been hospitalized **since** your last visit?
    Yes ___ No ___
18. If yes, please state the reason(s):
    ____
    ____
19. Have you had any surgeries **since** your last visit?
    Yes ___ No ___
20. If yes, please list them:
    ____
    ____

Source of information, if other than the patient:

____

Signature of person acquiring this information:

____

Signature of patient **Date**

______________________ ______________

Signature of parent/guardian **Date**

______________________ ______________

Michael S. Bloch, D.P.M.
Roland J. Carroll, III, D.P.M.
Chul Kim, D.P.M.
Brian C. Park, D.P.M., Q.M.E.
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MISSED APPOINTMENT POLICY

We thank you for choosing us as your healthcare provider. In order to give you and all our patients, the best possible care, we request you review our policy regarding missed appointments. **A missed appointment is when you fail to show up for an allotted appointment time, without a phone call or cancellation notice of at least 48-hours.** Please remember that we have reserved appointment times especially for you.

If you are unable to keep your scheduled appointment time, we request you please call our office at least 48 hours in advance in order to avoid a missed appointment fee. If you fail to give us notice, you will be charged a $25.00 missed appointment fee. This charge is not covered by insurance.

I have read and understand the policy stated above.

____
Patient / Guardian Signature

____
Date

____
Patient Printed Name

PATIENT CONSENT FOR MEDICAL PHOTOGRAPHY

I consent for medical imaging to be made of me or my child (or for person whom I am legal guardian). I understand that the information may be used and shown in my medical record and for purposed of medical education of medical professionals, staff, and patients at medical conferences, in office and via electronic publication. By consenting to this medical photography, I understand that I will not receive payment from any party. Refusal to consent to photographs will in no way affect the medical care I will receive. Although these photographs will be used without identifying information such as my name, I understand that it is possible that someone may recognize me. By signing this form below, I confirm that this consent form has been explained to me in terms which I understand.

____
Patient / Guardian Signature

____
Date

____
Patient Printed Name

☐ I agree to the use of my image for medical records ONLY

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 / Guardian Signature

____
Date

____
Patient Printed Name

GENERAL CONSENT TO CARE

I, the undersigned, for myself or a minor child or another person for whom I have authority to sign, hereby consent to medical care and treatment, as ordered by and Archstone Foot and Ankle Specialist provider, on an outpatient/office visit basis. This consent includes my consent for all medical services rendered under the general or specific instructions of a provider or the designees under the directions of a physician, as deemed reasonable and necessary. I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me as to the result of treatments or examinations at Archstone Foot and Ankle Group.

____
Patient / Guardian Signature

____
Date

____
Patient Printed Name