Date: ___________________

Patient Name: ____ **Date of Birth**: ________________**Age**: ______ **Sex**: M F

Home Address: ____ **City/State**: _________________________ **Zip**: _______

Home Phone #:_________________ **Cell #**:_________________**Work #**:________________ **Emergency #**:_______________

SSN: __________________ **Marital Status**: M S P W D Sep **Email address**:_____________________________________

Responsible Party (other than patient): ______________________________ **Relationship to patient**: _____________

Address: ____ Date of Birth: ____________________

Primary Language: _______ **Race**: White___ Black or African American ___ Asian ___ Native American___ Hawaiian ___

Ethnicity: Hispanic or Latino ____ Not Hispanic or Latino ____

Employer: ____ Occupation: _____________________________________

Primary Care Doctor: ______________________________________ Address: _____________________________________

Date of last visit to Primary Doctor: ______________________

Pharmacy: ____ Location: ____

How did you hear about this office?
____

Reason for your visit today: ____

Please CIRCLE any past or current Medical Problems:

DIABETES HIGH BLOOD PRESSURE HIGH CHOLESTEROL HEART DISEASE HEART ATTACK A-FIB

BREAST CANCER COLON CANCER LUNG CANCER OTHER CANCER (specify) ________________________________

ARTHRITIS ASTHMA C.O.P.D GOUT **HYPER**THYROIDISM **HYPO**THYROIDISM CATARACTS GLAUCOMA

DEPRESSION ANXIETY GERD/REFLUX PARKINSON'S DISEASE HEARING LOSS BIPOLAR DISORDER

OTHER (please specify): ____

SOCIAL HISTORY: Tobacco Use: Never ____ Sometime ____ Everyday ____ # yrs. Smoking ____ # packs/day ______

Former ____ Quit Date______

Alcohol Use: Daily ____ Social ____ None ___

PREVIOUS SURGERIES (please list): ____

____

FAMILY HISTORY: (i.e. High Blood Pressure, Diabetes, Heart Disease, etc.) **Please specify**

Mother: ____________________________________ Father: ____

Brother: ____________________________________ Sister: ____

ALLERGIES: None Known: ______ Medication Allergies: ____

MEDICATIONS: Please list all you are currently taking (including prescriptions, over-the-counter meds, and herbal supplements: (Or provide a copy of your current list)

Name/Dose/Frequency

____

____

____

HEIGHT: ___________ **WEIGHT**: __________ **BLOOD PRESSURE**: ___________

****

SIGNATURE ON FILE: I authorize the use of this form on all my insurance submissions and authorize the release of information to all my insurance companies. I authorize my doctor to act as my agent in helping me obtain payment from my insurance company. I authorize payment direct to my doctor. I permit a copy of this authorization to be used in place of the original. **I understand that I am responsible for my bill.**

____ ____________________________

Signature **Date**

HIPAA Privacy Practices Acknowledgement: I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

____ ____________________________

Signature **Date**

CONSENT FOR TREATMENT:

- I consent to receiving care at the office of Jeffrey M. Keating, DPM which is necessary or beneficial, including, but not limited to, the administration of medications, injections, x-ray examinations, laboratory procedures, and services as may be deemed necessary or advisable by my care provider(s).
- I understand that my healthcare team may be comprised of physicians, residents, students, other employees, and agents.
- I understand that the practice of medicine and surgery is not an exact science and I acknowledge that no guarantees are made as to the results of my treatment or procedures performed.
- I understand that for my health and protection, as well as the protection of others, I will not be permitted to have weapons, illicit drugs, alcoholic beverages or unauthorized electrical/electronic appliances with me during my care/treatment.
- I understand that during my treatment photographing, videotaping, audio recording, and/or televising (Recordings) may occur for care/treatment or identification purposes and will become part of my medical record.
- I understand that I have the right to refuse any medications, treatment, procedures, or Recordings to the extent permitted by law.

AUTHORITY TO REVIEW AND RELEASE RECORDS AND INFORMATION:

- I understand that Reading Hospital and Reading Health Physician Network have a system-wide, integrated electronic medical record that is available to caregivers on a "need to know" basis to share information about patient care provided in the hospital, outpatient, or physician office settings.
- I understand confidentiality of records including those reflecting treatment for behavioral health issues, HIV/AIDS, or drug and alcohol treatment is maintained per relevant governmental and regulatory standards.
- I understand that my After Visit Summaries are sent to designated Reading Health Physician Network and/or community primary care/family, referring physicians, as well as physicians who are consulted by the attending physician for coordination of care.

CARE EVERYWHERE PARTICIPATION:

- I understand that providers may request access to my protected health information from other participating providers, from whom I have received previous care, through an electronic health record system called ***Care Everywhere***.
- I understand that I have the option to "opt out" from allowing ***Care Everywhere*** providers to access my protected health information.
- I understand that if I choose to "opt out" that my choice will not affect my ability to receive medical care.

RELEASE OF RESPONSIBILITY FOR PERSONAL VALUABLES:

- I understand Jeffrey M. Keating, DPM does not accept responsibility for loss or damage to any monies, valuables, and/or personal property brought to Dr. Keating's office.

PATIENT RIGHTS AND RESPONSIBILITIES:

- I understand that I have patient rights which reflect Reading Health Physician Network's commitment to maintaining my personal dignity while providing me with the healthcare services I need.
- I understand that I have responsibilities to provide the healthcare team with certain information and support.
- I understand that I have the responsibility to respect the rights of others.
- I understand that if I have any concerns regarding my care, I may talk with my doctor, nurse, or any member of my healthcare team.

ACKNOWLEDGEMENT FORM:

- I have read this form (or had it read to me) in its entirety, have had any questions answered to my satisfaction, consent to each of the above provisions, and am signing this form knowingly and voluntarily.

______________________________	____________________	______________
Signature of Patient	Date	Time
______________________________	____________________	______________
Signature of Authorized Agent/Rep	Date	Time
______________________________		
Relationship to Patient		