Welcome

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have questions we'll be glad to help you. We look forward to working with you in maintaining your health.

Patient Information

Name _____ Soc. Sec.# _____
Last Name **First Name** **Initial**

Address _____

City _____ State _____ Zip _____ Home Phone _____

Cell Phone _____ Email _____

Sex ☐ **M** ☐ **F** **Age** _____ **Birthdate** _____ ☐ **Single** ☐ **Married** ☐ **Widowed** ☐ **Separated** ☐ **Divorced**

Patient Employed by _____ Occupation _____

Business Address _____ Business Phone _____

Business Email _____

Whom may we thank for referring you? _____

Notify in case of emergency _____ Home Phone _____ Cell Phone _____

Business Phone _____ Email _____

Primary Insurance

Person Responsible for Account _____
Last Name **First Name** **Initial**

Relation to Patient _____ Birthdate _____ Soc. Sec.# _____

Address (if different from patient) _____

City _____ State _____ Zip _____ Home Phone _____

Cell Phone _____ Email _____

Person Responsible Employed by _____ Occupation _____

Business Address _____ Business Phone _____

Business Email _____ Insurance Email _____

Insurance Company _____ Phone _____

Contract # _____ Group # _____ Subscriber # _____

Name of other dependents under this plan _____

Additional Insurance

Is patient covered by additional insurance? ☐ **Yes** ☐ **No**

Subscriber Name _____ Relation to Patient _____ Birthdate _____

Address (if different from patient) _____ Soc. Sec. # _____

City _____ State _____ Zip _____ Home Phone _____

Cell Phone _____ Email _____

Subscriber Employed by _____ Business Phone _____

Business Email _____ Insurance Email _____

Insurance Company _____ Phone _____

Contract # _____ Group # _____ Subscriber # _____

Name of other dependents under this plan _____

Please complete both sides.

Family Medical History

	Age	Good Health	Poor Health	Deceased
Father				
Mother				
Brother(s)				
Sister(s)				
Grandparent(s)				

Medical History

Date of last visit _____ Have you had any serious illnesses or operations? ☐Y ☐N

If yes, describe _____

Are you currently under physician care? ☐Y ☐N If yes, describe _____

Have you ever had a blood transfusion? ☐Y ☐N If yes, give approximate dates _____

Have you ever taken Fen-Phen/Redux? _____

Women: Are you pregnant? ☐Y ☐N Nursing? ☐Y ☐N Taking birth control pills? ☐Y ☐N

Check Y for yes or N for no if you have had any of the following:

☐Y ☐N AIDS/HIV Positive
☐Y ☐N Alcohol/Drug Abuse
☐Y ☐N Anaphylaxis
☐Y ☐N Anemia
☐Y ☐N Arthritis, Rheumatism
☐Y ☐N Artificial heart valves
☐Y ☐N Artificial joints
☐Y ☐N Asthma
☐Y ☐N Atopic (allergy prone)
☐Y ☐N Back problems
☐Y ☐N Blood disease
☐Y ☐N Cancer
☐Y ☐N Chemical dependency
☐Y ☐N Cholesterol problems
☐Y ☐N Chemotherapy
☐Y ☐N Circulatory problems
☐Y ☐N Cortisone treatments
☐Y ☐N Cough, persistent
☐Y ☐N Cough up blood
☐Y ☐N Diabetes
☐Y ☐N Epilepsy
☐Y ☐N Fainting
☐Y ☐N Food allergies
☐Y ☐N Glaucoma
☐Y ☐N Headaches
☐Y ☐N Heart murmur
☐Y ☐N Heart problems
Describe _____
☐Y ☐N Hemophilia/ Abnormal Bleeding
☐Y ☐N Hereditary Problems
☐Y ☐N Herpes
☐Y ☐N Hepatitis
☐Y ☐N High blood pressure
☐Y ☐N Jaw pain
☐Y ☐N Kidney disease or malfunction
☐Y ☐N Liver disease
☐Y ☐N Material allergies (latex, wool, metal, chemicals)
☐Y ☐N Mitral valve prolapse
☐Y ☐N Mother used alcohol, smoked, or used recreational drugs during pregnancy
☐Y ☐N Nervous problems
☐Y ☐N Pacemaker/Heart surgery
☐Y ☐N Psychiatric care
☐Y ☐N Rapid weight gain or loss
☐Y ☐N Radiation treatment
☐Y ☐N Respiratory disease
☐Y ☐N Rheumatic/Scarlet fever
☐Y ☐N Seizures
☐Y ☐N Shingles
☐Y ☐N Shortness of breath
☐Y ☐N Skin rash
☐Y ☐N Spina bifida
☐Y ☐N Stomach or Intestinal problems
☐Y ☐N Stroke
☐Y ☐N Surgical implant
☐Y ☐N Swelling of feet or ankles
☐Y ☐N Thyroid disease or malfunction
☐Y ☐N Tobacco habit
☐Y ☐N Tonsillitis
☐Y ☐N Tuberculosis
☐Y ☐N Ulcer/Colitis
☐Y ☐N Venereal disease

List medications you are currently taking, if any:

_____

_____

List drug allergies, if any:

_____

_____

Authorization

I have reviewed the information on this questionnaire and it is accurate to the best of my knowledge. I understand that this information will be used by the doctor to help determine appropriate treatment. If there is any change in my medical status, I will inform the doctor.

I authorize my insurance company to pay to the doctor or medical group all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions.

I authorize the doctor to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance.

Signature _____ Date _____

Payment is due in full at time of treatment unless prior arrangements have been approved.

DR. DITRA S. SCRUGGS, D.P.M.

NO CALL/ NO SHOW

Effective January 1, 2016, a $25.00 NO CALL/NO SHOW FEE has been implemented.

*I _____, acknowledge that this fee is to be paid in full no later than my next appointment. In the event that I call to cancel my appointment 24 hours in advance, I will leave a message on the voicemail at **410-653-7744**. I understand that voice mails are retrieved periodically throughout the day and that if no voice mail is left I am responsible for this fee.*

PAPER WORK

Effective January 1, 2016, a $25.00PAPER WORK FEE has been implemented.

*I _____, acknowledge that this fee is to be paid in full at the time paperwork is dropped off. There will be a **7-10 business day turn** around for all paperwork to be completed. I understand that I will receive a call once the paperwork has been completed.*

CHECKS

Effective January 1, 2016, a $40.00 RETURNED FEE has been implemented.

*I _____, acknowledge that there is a $40.00fee associated with any bad/bounced checks. This fee is to be paid in full, no later than my next appointment via cash/credit. In the event that a check is bounced, I understand that I will no longer be able to write a check for any balances/co-pays/deductibles. **As a one-time courtesy**, I understand that a check can be post dated until the end of the week that my appointment is scheduled for.*

Patients Signature: _____

Witness Signature: _____

19 WALKER AVE., SUITE 200
PIKESVILLE, MD 21208
(410) 653-7744
(410) 653-7745 FAX

"Remember Healthy Feet Are Happy Feet"

Office Notice of Privacy Practices for Dr. Ditra S. Scruggs, DPM

Patient Responsibility:

1. *To keep the office up to date with current demographic information, and to provide comprehensive health information including past and present illnesses, allergies and medication.*
2. *To inform the Physician and hospital of any directive or designated representatives.*
3. *To inform the staff immediately if there is any question related to diagnosis, care and treatment.*
4. *To conduct oneself in a fair and courteous manner, considerate with staff and other patients.*
5. *To keep appointment or telephone the office when an appointment cannot be kept.*
6. *To promptly make arrangements for payment of bills and/or ask questions concerning that bill.*
7. *To inform the physician, or staff of any concerns or suggestions either during the stay or after the appointment.*

Privacy Statement:

This office has always worked diligently to keep your health information secure and confidential. A new law requires us to maintain your privacy, to give you notice and to follow the terms of this notice.

Lawful Use of Medical Records:

The law permits us to use or disclose your health information to those involved in your care, for example:

1. *A portion of your file may be provided to a Specialist Physician who is involved in your care.*
2. *We may use or disclose your health information for payment of services, such as sending a report of your progress to your insurance company.*
3. *We may use or disclose your health information for our normal healthcare operations, such as staff entering your information into our computer filing system.*
4. *We may also use your information to contact you. For example, calling to remind you of appointments or test results. If you are not home, only limited information will be left on voice mail or with whoever answers the phone.*
5. *In an emergency, we may disclose your health information to a family member or another person responsible for your care.*
6. *We may release some of your information when required by law, but will make every attempt to contact you for authorization.*
7. *If this practice is sold, your information will become the property of the new owner.*

Except as described above, this practice will not use or disclose your health information without your prior written authorization.

Your Rights Regarding Your Personal Records:

1. *You may request in writing that we may not use or disclose your health information as described above. We will let you know if we can fulfill that request.*
2. *You have the right to know of any uses or disclosures we make with your health information beyond normal uses.*
3. *You have the right to transfer copies of your health information to another practice. You have the right to see or and receive a copy of your health information, with few exceptions. Give us a written request regarding the information you would like copied and who to send it to. A reasonable fee will be applied.*
4. *You have the right to request an amendment or change to your health information. Give us your request in writing. If we agree to the amendment or change, we will not remove nor alter earlier documents, but will add new information.*
5. *You have the right to receive a copy of this notice. If we change any of the details of this notice, we will notify you in writing. If you have a complaint for more information or assistance regarding your health information privacy, please contact our offices and the Physician or office manager will be more than happy to assist you.*

Acknowledgment. I have receive a copy of the Privacy Practices for this office:

*SIGNED:*_____ *DATE:*_____

Date _____

Name _____

Address _____

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

Phone _____

Date of Birth _____

Physician / Office _____

Address _____

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

Phone _____

Peripheral Artery Disease (PAD) is a common circulation problem in which arteries carrying blood to the legs are not functioning well or become narrowed or clogged due to a build-up of plaque.

Fill out this questionnaire so your physician can evaluate whether you may be at risk or have symptoms of PAD.

Circle YES or NO on the following questions and check all boxes that apply:

1 Have you ever been diagnosed with Peripheral Vascular Disease or been diagnosed as having poor circulation? **YES NO**

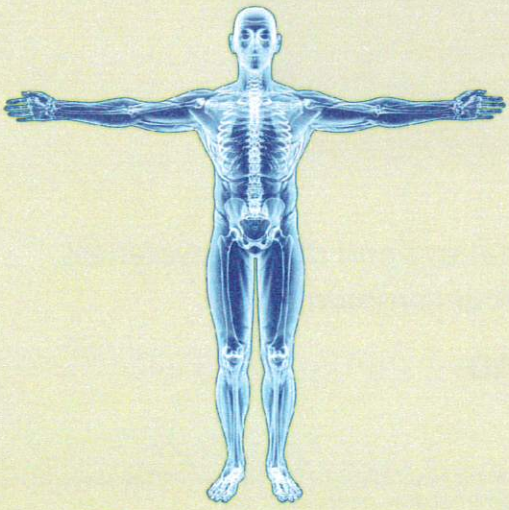
2 Have you ever had surgery, balloon procedures or stents in your heart, kidneys, belly, legs, or arms? If yes, dates: **YES NO**

3 When you walk, do you experience aching, cramping or pain in your legs, thighs, or buttocks? **YES NO**

4 If you answered Yes to #3, when do you feel the pain:

- ☐ After walking 1 block
- ☐ Climbing a flight of stairs
- ☐ After walking 100 yards
- ☐ Walking at increased speed

5 If you answered Yes to #3, circle the area(s) of the body on the diagram below where you feel pain.



6 If you have pain, does the pain subside with rest? **YES NO**

7 Do your feet or toes bother you most nights while lying in bed, with relief when they are dangled at the edge of the bed? **YES NO**

8 Do you have any painful sores or ulcers on legs or feet that do not heal? **YES NO**

9 Are your legs discolored or bluish? **YES NO**

10 Check all that apply:

- ☐ I am a current smoker
- ☐ I have a history of smoking
- ☐ I have diabetes
- ☐ I have a family history of diabetes
- ☐ I have high cholesterol
- ☐ I have a family history of high cholesterol
- ☐ I have high blood pressure/hypertension
- ☐ I have a family history of high blood pressure/hypertension
- ☐ I have coronary artery disease (CAD)
- ☐ I have a family history of coronary artery disease
- ☐ I have had a stroke/mini-stroke/TIA
- ☐ I have a family history of stroke/mini-stroke/TIA

Physician Information

If you happen to have your primary care doctor's business card on hand, please bring it to the receptionist so that a copy can be made. Thanks you!

Name of Primary Care Physician:

Address:

Telephone:

Fax:

Date of Last Visit:

Are you now or have you been, under any other doctor's care for any reason over the past two years:

Yes ***No***

If yes, please explain:

For Office Use ONLY!!
NPI:

Provider Tax ID:

List of Medications

If you happen to have a card of a sheet of paper with your list of medications on it, please bring it to the front so that a copy can be made. Thank you!

Please list medications, the dosage if known, and how often you take the medication:

1) _____

2) _____

3) _____

4) _____

5) _____

6) _____

7) _____

8) _____

9) _____

10) _____

Pharmacy Information

Name of Pharmacy:

_____

Address:

_____

Telephone:

_____

Fax:

_____