Central Louisiana Foot and Ankle Specialists

My Primary Care Provider (PCP) is: ____

Do you have a Medical Power of Attorney? □ **Yes** □ **No**

Do you have a Living Will? □ **Yes** □ **No**

Patient Information

Patient Legal First Name: ______________________________ Middle Initial: _________ Last Name: _______________________________

Date of Birth: _______________ Sex: Male/Female Social Security #: ____________________ Email: ______________________________

Home Address : ____ City: ____________________ State: ________ Zip: _______________

Mailing Address: ____ City: ____________________ State: ________ Zip: _______________

Home Phone: _____________________________ Mobile Phone: _____________________ Work Phone: ____________________________

How do you want us to contact you: Home □ Cell □ Work □ Marital Status: _____M _____S _____D _____W _____Other

Language Preference: □ English □ Other: ____________________ Race: ______________________ Ethnicity: Hispanic/Non-Hispanic/Decline

Employer: ____□ Retired

Employer Address: ______________________________ City: ______________________________ State: ________ Zip: ________________

Responsible Person's or Spouse Information

Legal First Name: ______________________________ Middle Initial: _________ Last Name: _____________________________________

Date of Birth: _______________ Sex: Male/Female Social Security #: ____________________ Email: ______________________________

Address : ____ City: ____________________ State: ________ Zip: _______________

Home Phone: _____________________________ Mobile Phone: _____________________ Work Phone: ____________________________

Employer: ____

Employer Address: ______________________________ City: ______________________________ State: ________ Zip: ________________

Emergency Contact

Name: ____ Relationship: _______________________ Phone #: _______________________

Mother's Name/Legal Guardian if Patient is a Minor: ____

Authorized Contacts:

Please list all persons who are allowed to inquire/discuss/relay information pertaining to your personal health information.

1) Name: ____ Relationship: _________________________ Phone #: _________________

2) Name: ____ Relationship: _________________________ Phone #: _________________

3) Name: ____ Relationship: _________________________ Phone #: _________________

Insurance Information

Primary Insurance: ______________________________ Policy #: _______________ Group #: _______________ Policy Holder DOB: ________

Policy Holder Name: _______________________________ Policy Holder Social Security #: _______________ Relationship: ________________

Secondary Insurance: ____________________________ Policy #: _______________ Group #: _______________ Policy Holder DOB: _________

Policy Holder Name: _______________________________ Policy Holder Social Security #: _______________ Relationship: ________________

Preferred Pharmacy

Name: ______________________________ Street: ______________________ City: ___________________ Phone #: ________________

Cenla Family Medicine Associates, LLC
Central Louisiana Foot and Ankle Specialists
Cardiac and Vascular Services of Cenla
Alexandria Gastroenterology Associates

Patient's Notification and Signature Form

Print Patient Name: ____ Date of Birth: ____________________

Please initial all:

I have received a copy and have read the HIPPA Notice of Privacy Practices Policy for the clinic.
_____ Patient or Guardian's Initial

I have received a copy and have read the Patient Consent for Use and Disclosure of Protected Health Information Policy for th e clinic.
_____ Patient or Guardian's Initial

I have received a copy and have read the Payment Policy for the clinic. _____
Patient or Guardian's Initial

I have received a copy and have read the No Show Policy for the clinic.
_____ Patient or Guardian's Initial

I have received a copy and have read the Authorization of Care for the clinic.
_____ Patient or Guardian's Initial

I authorize the release of any information necessary to process this claim and authorize payment of benefits to Cenla Family Medicine Associates, LLC, Central Louisiana Foot and Ankle Specialists, Cardiac and Vascular Services of Cenla, and/or Alexandria Gastroenterology Associates for services rendered. I understand that I am financially responsible for all charges whether or not covered by insurance.
_____ Patient or Guardian's Initial

I authorize my insurance company to pay benefits directly to Cenla Family Medicine Associates, LLC and/or Cardiac and Vascular Services of Cenla for charges relating to all services.
_____ Patient or Guardian's Initial

<u>PRESCRIPTION HISTORY CONSENT</u>
I agree that the clinic may request and use my prescription medication history from other healthcare providers or third-party pharmacy benefit payers for treatment purposes.

Yes______ (please initial) **No _______ (please initial)**

I recognize my responsibility and my rights as a patient of Cenla Family Medicine Associates, LLC , Central Louisiana Foot and Ankle Specialists and/or Cardiac and Vascular Services of Cenla.

_______________________________________ ___________________________
Patient or Guardian's Signature Date

CENLA FAMILY MEDICINE ASSOCIATES PATIENT/PROVIDER AGREEMENT

Good communication between patients and physicians/providers is the key to better outcomes. The staff at Cenla Family Medicine Associates, offices of Dr. Screpetis, Dr. McBride, Dr. Buck, Dr. Michelle Beurlot, Dr. Jonathan Hunter, Dr. Maria Saucier, Dr. Paul Sunderhaus, Dr. Joseph Hollier, Kim Sills, FNP, Frances Turregano, FNP, Dana Homer, FNP, Amy Langston, FNP and Tina Billberry, FNP are committed to providing you the highest quality medical care. This can best be accomplished by a clear understanding about our responsibilities to you, and your rights and responsibilities as a patient in our practice.DM

Our Responsibilities to You:

- Respect you as an individual – we will not make judgments based on race, ethnicity, national origin, religion, gender, age, physical disability, sexual orientation, or genetic information.
- Respect your privacy – your medical information will not be shared with anyone else unless you give permission or as required by law.
- Provide “whole person” care based on the best possible treatment and advice based on current medical evidence – we respect your right to information and will discuss appropriate or medically necessary treatment options regardless of cost or benefit coverage.
- Manage your health status, including well person/preventive care as well as treatment for acute and chronic diseases.
- Coordinate your care and services with other healthcare providers and settings.
- Provide you timely access to care in our practice, as well as facilitate timely access to specialists, diagnostic services, and other care as needed.

Your Responsibilities to Us:

- Ask questions, share your feelings and be part of your care.
- Be honest about your history, symptoms, and other important information about your health.
- Tell your provider about any changes in your health and well-being, including visits to other medical providers and/or facilities and providing any associated medical records.
- Take your medicine as ordered and follow your provider’s advice – if you are unwilling or unable to do so, be honest with your provider.
- Make healthy decisions about your daily habits and lifestyle.
- Prepare for and keep scheduled visits or reschedule visits in advance whenever possible.
- Call your provider first with all problems unless you have a medical emergency.
- End every visit with a clear understanding of your provider’s expectations, treatment goals and future plans.

PLEASE NOTE: Cenla Family Medicine is open Monday through Thursday, 7:45am to 5:00 pm and Friday 745 to 12:00 pm. There is a provider available to see you or consult with you during these hours. When the office is closed, there is an on-call provider available for urgent issues which cannot wait until regular office hours. To access the on-call provider, call the regular office phone number and you will be automatically connected for immediate assistance.

By signing below, you indicate that you have read this document, and that it is your wish to join our medical home and to do your best to abide by the statements listed above. This is not a legally binding contract but is intended to provide a framework upon which we can build a relationship that will allow you to maximize your health status in a comfortable and welcoming environment.

______________________________	________________________________	_____________
Patient Name	Patient Signature	Date

______________________________	_____________
Provider or Representative Signature	Date

Central Louisiana Foot & Ankle Specialists
Paul T. Sunderhaus, DPM
Maria N. Saucier, DPM
1587 N. Bolton Ave, Suite 1500
Alexandria, LA 71303
318-445-9210

Patient Information:

Name: ____ Date: ____________________

Primary Care Physician (PCP): ____

Last date seen by Primary Care Physician: ____

Other Physician(s) involved in your care: ____

What foot/ankle problems are you having: ____

____

How Long has it been going on? ____

Where is your pain / problems? ____

Did it come on suddenly? YES / NO Gradually? YES / NO Injury: YES / NO

If there was an injury, when and how did it occur? ____

____

What makes the pain worse? ____

Any previous treatment? ____

Who referred you? ____

Height ____________________ Weight ____________________ Shoe size ____________________

Past Medical History - please circle any current or prior conditions:

AIDS/HIV
Anemia
Angina
Arthritis
Asthma
Back Problems
Back Pain
Bleeding Disorders
Blood Clots
Cancer: ________________________
Cellulitis
Chest Pain
Congestive Heart Disease (CAD)
Diabetes
Diarrhea
Emphysema
Epilepsy

Fibromyalgia
Fractures: ____________________
Gangrene
Gout
Headaches
Heart Disease
Heartburn / Reflux
Hemophilia
Hepatitis or Jaundice
High Blood Pressure
High Cholesterol
Hip / Knee Pain
Kidney Problems or Dialysis
Liver Disease
Lupus
Neurological Disorder
Neuropathy

Numbness in Legs/Feet
Pancreatitis
Phlebitis
Polio
Numbness in Legs / Feet Heart
Psychiatric Disorders
Pulmonary Embolus
Respiratory Disease
Rheumatic Fever
Rheumatoid Arthritis
Sciatica
Seizures
Shortness of Breath
Sinus Problems
Stomach Ulcers
Stroke
Swelling in ankles / feet

Tuberculosis
Urinary Tract Infection
Varicose Veins
Venereal Disease
Weakness
Weight loss - unexplained

Past Surgical History: list all surgeries, not just foot-related, as well as approximate date.

____

____

____

____

____

Social History:

Employed: YES / NO Occupation: ____

Married / Single / Widowed / Other

Exercise: Never / Rarely / Monthly / Weekly / Daily Type of exercise: _____________________________

Tobacco Use: YES / NO Past / Current Packs/Day _________ Quit? How long ago?____________________

Alcohol Consumption: YES / NO #drinks per day/week/month (circle) ____________

Illicit drug use current or past: ____

Family History:

Relation: Age: Living: Deceased:

Mother: ____

Father: ____

______ Cancer

______ Hypertension

______ Diabetes

______ Stroke

Medications: List all medication, supplements, herbals, vitamins you use or take.

1.____ 9. ____

2. ____ 10. ____

3. ____ 11. ____

4. ____ 12. ____

5. ____ 13. ____

6. ____ 14. ____

7. ____ 15. ____

8. ____ 16. ____

What pharmacy do you use? ______________________________________ Phone #: ___________________________

Allergies: Medications, metals, latex, or foods and what happens when you are exposed.

Please list all allergies & if you have had a reaction, please describe:

____

____

____

To the best of my knowledge, I have answered the questions on this form accurately. I understand that providing incorrect or inaccurate information may be dangerous to my health. I understand that it is my responsibility to inform my doctor and office staff of any changes in my medical status.

____ _______________________

Patient Signature Date