List relationship to you of family members who have had:

Diabetes	Heart Attack
Arthritis	Stroke
Cancer	Birth Defects

Do you smoke now? Y N **Did you ever smoke?** Y N

Packs/ day Number of years

List any surgeries you have had:

Please describe the reason for your visit today:

Are you currently taking any medications? Yes No **If yes, list below.**

Are you currently taking insulin? Yes No **If yes, list below.**

_____

_____

What Pharmacy Do You Use:_____Phone#:_____

ASSIGNMENT OF INSURANCE BENEFITS

I/We hereby authorize payment of insurance benefits directly t Cumberland Foot and Ankle Center. These payments will not exceed my / our indebtedness for services rendered. I /we understand that personal information about me/us will be needed by the Doctor, and my insurance plan to determine and communicate what services or benefits are covered by my insurance plan, and to submit and process a claim for payment on services rendered and for the doctor to collect all fees owed for those services. Therefore, for the purpose of obtaining payment for services rendered, I/we give the doctor my insurance plan, the Centers for Medicare and Medicaid Services (CMS), their agents, and and/or any other holder of information about me/us, authorization to release and/or exchange medical, billing, and collection information. This assignment shall remain in effect until cancelled in writing by Cumberland Foot and Ankle Center. I/We agree to promptly pay any remaining balance due on all professional and medical services.

I further agree that Cumberland Foot and Ankle Center is authorized to act in my behalf in the endorsement of benefit checks made payable to me and/or Cumberland Foot and Ankle Center.

A photocopy of this agreement, or an electronic facsimile thereof, shall be considered as effective as the original.

Patient Signature or Authorized Agent **Date**

ACKNOWLEDGEMENT OF THE NOTICE OR PRIVACY PRACTICES

I hereby acknowledge that I have been made aware that the Cumberland Foot and Ankle Center Privacy Practices privacy policy is hanging in the patient waiting room and that is visible for my viewing. A paper copy is available at my request. The Privacy Policy sets forth the way in which my Protected Health Information may be used or disclosed and outlines my right with respect to such information. I also acknowledge that I have been allowed to ask questions. If I am not the patient, I represent that I am authorized by law to act for and on the patient's behalf.

_____ _____

Patient Signature or Authorized Agent **Date**