560 Riverside Drive, A-101
Salisbury, MD 21801
Phone: 410-749-0121
Fax: 410-749-6807

300 Aurora Street
Cambridge, MD 21613
Phone: 410-228-2305
Fax: 410-228-8521

Kevin Thomas, D.P.M. / Trina P. Monis, D.P.M. / Stephen V. Wilkinson, D.P.M. / John Thomas, D.P.M

FIRST_____ MI_____ LAST_____ AGE_____

ADDRESS_____CITY_____ST_____ZIP_____

PHONE: Home_____ Work_____ Cell_____

E-Mail address_____

Date of Birth_____ Social Security No._____ Gender _____M_____F

Employer's Name / Address_____

Primary Dr._____ Phone #_____ Date Last Seen_____

Emergency Contact_____ Relationship_____ Phone_____

Pharmacy/Address/Phone #_____

Who referred you to this office? _____

Reason you are here today? _____

How long have you had this problem / condition? _____

Symptoms you are experiencing? _____

Does anything make your symptoms feel better or worse? _____

Why?_____

Please rate your pain: At rest 1-10_____ At worst 1-10_____(10 being most painful)

WHEN YOU HAVE TO GO TO THE DENTIST, DO YOU HAVE TO TAKE ANTIBIOTICS DUE TO HEART MURMUR OR ARTIFICIAL JOINTS? YES _ _ NO_____

DOES ANY OF THE FOLLOWING APPLY TO YOU?

Chest Pain	**YES_____NO_____ WITH / WITHOUT EXERTION**		
Shortness of Breath	**YES_____NO_____ WITH / WITHOUT EXERTION**		
Coughing	**YES_____NO_____**	**Wheezing**	**YES_____NO_____**
Dizziness	**YES_____NO_____**	**Fainting**	**YES_____NO_____**
Nausea	**YES_____NO_____**	**Vomiting**	**YES_____NO_____**
Back Pain	**YES_____NO_____**	**Joint Pain**	**YES_____NO_____**
Prolonged Bleeding	**YES_____NO_____**	**Immune or Healing Disorders**	**YES_____NO_____**
Pregnant	**YES_____NO_____**	**Nursing**	**YES_____NO_____**

HAVE YOU EVER BEEN TREATED FOR:

Diabetes	**YES_____NO_____**	**Rheumatic Fever**	**YES_____NO_____**
Heart Trouble	**YES_____NO_____**	**Kidney Ailments**	**YES_____NO_____**
Asthma	**YES_____NO_____**	**Liver Ailments**	**YES_____NO_____**
COPD	**YES_____NO_____**	**MRSA**	**YES_____NO_____**
Stomach Ailments	**YES_____NO_____**	**Foot Ulcers**	**YES_____NO_____**
Gout	**YES_____NO_____**	**High Blood Pressure**	**YES_____NO_____**
Cancer	**YES_____NO_____ TYPE_____**		
Tuberculosis	**YES_____NO_____**		

OTHER MEDICAL PROBLEMS OR SURGERY NOT LISTED: _____

SIGNATURE_____**DATE**_____

PATIENT_____ **DOB**_____

MEDICATIONS – INCLUDE DOSAGE (PILL, LIQUID, INJECTION)

_____
_____
_____
_____
_____
_____

MEDICATIONS YOU ARE ALLERGIC TO

MEDICATION	REACTION	MILD, MODERATE, SEVERE

SURGERY HISTORY

Procedure_____ **Date**_____
Procedure_____ **Date**_____
Procedure_____ **Date**_____
Procedure_____ **Date**_____

Do you have any artificial joints? ( ) YES ( ) NO
PLEASE LIST_____
Do you have an artificial heart valve? ( ) YES ( ) NO

SOCIAL HISTORY

Please check one: [ ] Married [ ] Single [ ] Divorced [ ] Widowed

Weight_____ **Height**_____ **Shoe size**_____ **Width**_____

Do you smoke? ____YES ____NO How many packs per day? _____ For how long?_____

Do you drink alcohol? ____YES ____NO How often? _____

Substance abuse: ____YES, I have or have had a substance abuse problem.

Specify_____

Are you employed? _____YES _____NO _____RETIRED _____UNEMPLOYED

What is your occupation? _____

Race_____ **Ethnicity**_____ **Preferred Language**_____

Patient Signature_____**Date**_____

Name: _____**DOB:** _____

Insurance Information, please complete and provide cards for scanning

PRIMARY INS CO: _____**POLICY HOLDER'S NAME:** _____**DOB:** _____

SECONDARY INS CO: _____**POLICY HOLDER'S NAME:** _____**DOB:** _____

Do you have an HSA or HRA account? ( ) No ( )Yes Card #_____**Expiration**_____

Did your foot problem result from a specific injury ( ) No ( )Yes Injury Date_____/_____/____

How did your injury occur? _____

Is this a Worker's Compensation Claim? ( )No ( )Yes Claim #_____

Contact: _____**Phone:** _____

Authorization for Treatment/Insurance Authorization/Financial Agreement

I hereby grant authority to Dr. Kevin Thomas and associates to administer medical treatment to my dependent minor or student family member and me. Further, I hereby authorize my insurance carrier to pay medical and/or surgical benefits directly to Kevin Thomas D.P.M., PC. I authorize Kevin Thomas, D.P.M., PC to release any information acquired in the course of my treatment needed for medical insurance claims or consultations. A photocopy of this authorization is to be considered as valid as the original until revoked by me in writing. Participation with your insurance company requires us to collect your copay and deductible amounts. These are due at the time services are rendered, as are non-covered services. A $10.00 fee may be added if not paid. I understand that I am financially responsible for all charges made to my account whether or not an insurance company, attorney, or other third party payer is involved with payment. I am responsible for all co-payments and co-insurance amounts, non-covered supplies and services and yearly deductibles. I agree to pay all collection expenses including a $35.00 return check fee, attorney's fees, court costs, filing fees, including charges that may be assessed by any collection agency retained to pursue this matter. As of 6/1/2012 there may be a $40.00 for missed appointments. _____ **Initials**

Statement of Disclosure House Bill 1280
Health Care Practitioners-Referral of Patients

Kevin Thomas, D.P.M., PC owns Riverside Ambulatory Surgery Center, LLC. If you have health care services scheduled at the above facility please know that a valid medical need exists for this referral and that you have the option of selecting another health care facility for these services.
I acknowledge receipt of this information and the options available to me to select another health care facility should I so choose.

Privacy Information Preferences

- Can we leave voicemail on answering machine? _____Yes _____No
- I authorize discussion of my personal health information with the following person(s):

Name: _____Relationship: _____Phone: _____

Name: _____Relationship: _____Phone: _____

Privacy Practice

I acknowledge that I was provided a copy of the Privacy Practice of Kevin Thomas, D.P.M., PC and Riverside Ambulatory Surgery Center, LLC. And that I have read (or had the opportunity to read if I so choose) and understood the Notice.

Today's Date _____/_____/_____

Signature: _____

Parent/Guardian Signature: _____

WELCOME TO OUR OFFICE: Thomas Podiatry & Associates

PLEASE ARRIVE 30 MIN. PRIOR TO YOUR APPOINTMENT TIME.

In an effort to better serve you, please fill out the entire packet of information prior to your scheduled visit.

Please complete the following items:

_____ Patient Information Sheet _____ Insurance Authorization Form

_____ Office Policy Form _____ Privacy Practices Acknowledgement

WE ACCEPT CASH, CHECK OR CREDIT CARDS FOR PAYMENT

Please bring your **INSURANCE CARD(S)** so that we can copy them.

If your insurance requires you to have a referral, please obtain one from your primary care physician **PRIOR** to the date of your visit. Without the referral your insurance will not pay for the visit and you will be responsible for the charges.

Bring your **MEDICATIONS** with you or a list of the medications you are currently taking.

Please bring a calendar with you to assist us in making appointments for tests or for scheduling another appointment with our office that will be convenient for you.

If you are Diabetic and covered under Medicare, your insurance requires us to have the date last seen by your primary care physician in order for the visit to be paid. Please bring this information with you.

You may bring this information packet at the time of your visit or mail it to the appropriate address above. If you have any questions, please feel free to contact us.

OFFICE POLICY

We strive to give our patients the best care that we can. We know that your time is valuable, as is the doctors'; therefore: we ask that you arrive on time for your appointment.

If you are late for your appointment, you may be asked to re-schedule.

If you are unable to keep your scheduled appointment, please contact us within 24 hours. (We do have an answering machine where you can leave messages). We will do everything we can to accommodate your needs if possible.

If you fail to call to cancel your appointment or "NO SHOW" to your appointment, there will be a charge of $40.00 and another appointment cannot be made until this is paid. (Price is subject to change without notification).

If you fail to pay your Co-Payment before or after your appointment, while in the office, there will be $10.00 charge.

All Documents requiring Physician completion and a signature, will be a $25.00 charge and will have a ten (10) business day turn-a-round time, not to include weekends or holidays. The Office will notify you when the documents can be picked up.

There will be a $35.00 charge for any returned check. This charge and the amount of the check will need to be paid in cash or with a money order before another appointment is made.

Our office accepts CASH, CHECKS and CREDIT CARDS as form of payments.

_____ _____

Office Staff **Patient**

_____ _____

Date **Date**

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability and Accountability Act of 1996 ("HIPPA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- **Conduct, plan and direct my treatment and follow-up among the multiple providers who may be involved in that treatment directly or indirectly.**
- **Obtain payment from third-party payers.**
- **Conduct normal healthcare operations such as quality assessments and physician certifications.**

I have been given a copy (if requested) and the opportunity to read it and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request, in writing, that you restrict how my private information is used or disclosed to carry out treatment, payment or healthcare operations. I also understand that you are not required to agree to my requested restrictions, but if you do agree, then you are bound to abide by such restrictions.

Patient Name _____

Relationship to Patient _____

Signature _____

Date _____

Kevin Thomas DPM / Trina P. Monis DPM / Stephen V. Wilkinson DPM / John M. Thomas DPM

PHARMACY MEDICATION REQUEST

Patient Name: _____ **Date of Birth:** _____

Address:

_____

Name of Pharmacy:

_____

Please fax the most currant list of medication on file for the above named patient

1) Name of Medication
2) Dosage
3) Signature

Please fax to: Thomas Podiatry

Fax: 410-749-6807

Patient Signature: _____

Date: _____