New Patient Information

What is the reason for your visit today?

Patient Information					
Name (First, Last)	Birth Date	Age	Shoe Size	Birth Gender ☐ M ☐ F	
Mailing Address	Apt #	City, State, ZIP			
Primary Phone	Height	Weight	Race		

Emergency Contact		
Contact Name	Phone Number	Relationship to Patient

Primary Care Provider and Pharmacy	
Primary Care Provider	Preferred Pharmacy (Name, Address, Phone Number)

Medical Insurance		
PRIMARY Insurance Company Name	Policy # / Member ID	Group #
Insured Holders Name	Insured Date of Birth	Patient Relationship to Insured ☐ Self ☐ Spouse ☐ Dependent
Insurance Company Address (back of card)		Phone (back of card)

Medical Insurance		
SECONDARY Insurance Company Name	Policy # / Member ID	Group #
Insured Holders Name	Insured Date of Birth	Patient Relationship to Insured ☐ Self ☐ Spouse ☐ Dependent
Insurance Company Address (back of card)		Phone (back of card)

Patient Medical History

Today's Date: _____

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

Patient History

CIRCLE ANY CONDITIONS YOU ARE CURRENTLY BEING TREATED FOR OR HAVE HAD IN THE PAST:

Heart Disease	Anemia or other blood disease	Diabetes	Blood Clots
High Blood Pressure	Thyroid Disease	Cancer	Depression
High Cholesterol	Stomach Disease	Severe Headaches	Other Below:
Lung Disease	Kidney, bladder, prostate Disease	Stroke	_____

Allergies (medication, food, latex, or environmental)		No Known Allergies ☐
1.	2.	3.
Severity: ☐ Mild ☐ Moderate ☐ Severe	Severity: ☐ Mild ☐ Moderate ☐ Severe	Severity: ☐ Mild ☐ Moderate ☐ Severe
Reaction:	Reaction:	Reaction:

Current Medication (including non-prescription products)			No Current Medication ☐
1.	2.	3.	4.
5.	6.	7.	8.

Procedures/Surgeries (include approximate date)		
1.	2.	3.

Family History (indicate high blood pressure, diabetes, cancer, or other)		None ☐
Mother	Father	Grandmother (M)
Grandfather (M)	Grandmother (P)	Grandfather (P)

Other Health Issues

Do you drink alcohol? ☐ Yes ☐ No ☐ Beer ☐ Wine ☐ Liquor _____ per week

Do you use any forms of tobacco (include e-cigarette)? ☐ Yes ☐ No _____ per day, _____ years

Marijuana / recreational drug use? ☐ Yes ☐ No _____ per day, _____ years

BLUEWATER FOOT & ANKLE SPECIALISTS
1565 Sam Rittenberg Blvd. Suite 104
Charleston, SC 29407
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Consent to Routine Medical Treatment/Services

Patient consents to the rendering of Medical Treatment/Services as considered necessary and appropriate by Dr. Brandon Bultsma or physicians on staff at Bluewater Foot & Ankle Specialists. The consent to receive "Medical Treatment/Services" includes, but is not limited to: examinations (x-ray or otherwise); medications; drugs; supplies; medical treatments; and other services which Patient may receive.

Explanation of Risk and Treatment Alternatives

Patient acknowledges that the practice of medicine is not an exact science and that no guarantees or assurances have been made to the patient concerning the outcome and/or result of any Medical Treatment/Services. While routinely performed without incident, there may be material risks associated with each of these Medical Treatment/Services. By signing this form: Patient consents to Dr. Brandon Bultsma and Bluewater Foot & Ankle Specialists' staffed physicians to perform Medical Treatment/Services as they may deem reasonably necessary or desirable in the exercise of their professional judgment, including those Medical Treatment/Services that may be unforeseen or not known to be needed at the time this consent is obtained; and Patient acknowledges that Patient has been informed in general terms of the nature and purpose of the Medical Treatment/Services; the material risks of the Medical Treatment/Services and practical alternatives to the Medical Treatment/Services. If Patient has any questions or concerns regarding Medical Treatment/Services, Patient will ask Dr. Brandon Bultsma or associated physicians to provide Patient with additional information.

Authorization to Release Information

Bluewater Foot & Ankle Specialists is authorized to use and release information contained in the patient record as described in Bluewater Foot & Ankle Specialists' Notice of Privacy Practices and as otherwise permitted or required by law. Patient waives any privilege pertaining to such confidential information and hereby releases Bluewater Foot & Ankle Specialists, its agents and employees from any and all liabilities, responsibilities, damages, claims and expenses arising from the use and release of information as authorized above. Permissible uses and disclosures include, but are not limited to, disclosures to insurance companies, their agents or other third-party payors and/or government or social service agencies that may or will pay for any part of the medical expenses incurred or authorized by representatives of Bluewater Foot & Ankle Specialists. Patient acknowledges and agrees that patient's records will be available to all Bluewater Foot & Ankle Specialists affiliated entities and providers, and to non-Bluewater Foot & Ankle Specialists affiliated referring providers in compliance with the provisions of meaningful use. By consenting to treatment and accepting financial responsibility for any such treatment, Patient also understands and acknowledges that (a) Bluewater Foot & Ankle Specialists, from time-to-time, may call and/or text the cell number Patient has provided or email treatment-related information to Patient, such as appointment and exam confirmations and reminders, wellness checkups, pre-operative instructions, and prescription notifications, and (b) Patient's preferences to receive, change or stop these and other types of communications from Bluewater Foot & Ankle Specialists may be done by calling our office at (854) 444-3129.

Financial Policy and Disclosure

Self-Pay Policy: If you are a self-pay patient, you will be required to pay for the office visit and any account balance upon services being rendered.

Insurance Policy: It is our policy to file for insurance as a courtesy to you, if we have accurate and complete insurance information. If a service is provided that is not covered by your insurance company, you will be the responsible party at the time of service. If we have not received a payment from your insurance company within the contracted time frame specified by your insurance company's contract with Bluewater Foot & Ankle Specialists, you will be responsible for the balance due. Deductibles, co-payments, and coinsurance will be collected at the time services are rendered.

Overdue and Credit Balances: All over-due patient balances will be sent to collections following multiple failed attempts from Bluewater Foot & Ankle Specialists to collect payment from the patient. Please be sure to provide an accurate mailing address so you are receiving any balances.

Validity of Form

Patient understands that the Healthcare Professionals participating in the Patient's care will rely on Patient's documented medical history, as well as other information obtained from Patient, Patient's family or others having knowledge about Patient, in determining whether to perform or recommend care; therefore, Patient agrees to provide accurate and complete information about Patient's medical history and conditions. Patient confirms that Patient has read and understood and accepted the terms of this document and the undersigned is the Patient, the Patient's legal representative or is duly authorized by the Patient as the Patient's general agent to execute the above and accept its terms.

Patient/Patient Representative Signature	Patient Name (Printed)	Date
Relationship to Patient	Reason Patient is Unable to Sign	

Consent to Text Message for Appointment Reminders and Healthcare Communications

Patients in our practice may be contacted via email and/or text messaging to remind you of an appointment, to obtain feedback on your experience with our healthcare team, and to provide general health reminders/information. If at any time I provide an email or text address at which I may be contacted, I consent to receiving appointment reminders and other healthcare communications/information at that email or text address from Bluewater Foot & Ankle Specialists. _____ **(Patient initials)**

I consent to receive text messages from Bluewater Foot & Ankle Specialists at my cell phone and any number forwarded or transferred to that number or emails to receive communication as stated above. I understand that this request to receive emails and text messages will apply to all future appointment reminders/feedback/health information unless I request a change in writing. I authorize to receive text messages for appointment reminders, feedback, and general health reminders/information to the following Cell Phone number:

Cell Phone Number	( ) -		
Signature →		Name (print)	Date

Consent to Obtain Electronic Prescription History

As a user of an electronic medical record, Bluewater Foot & Ankle Specialists would like to include your medication history in your record. A medication history is a list of prescription medicines that we or other doctors have prescribed for you. This list is collected from several sources, including your pharmacy and your health insurance and electronic medical records. An accurate medication history is very important to help us treat you and to avoid potentially dangerous drug interactions and for obtaining prior authorizations that are often required by your insurance companies. By signing this consent form, you give us permission to collect, and give your pharmacy and your health insurance permission to give us, information about all prescriptions that have been filled at any pharmacy or covered by any health insurance. This information will become part of your electronic medical record.

Signature →		Name (print)	Date

HIPAA Privacy Authorization Form

Required by the Health Insurance Portability and Accountability Act, 45 C.F.R. Parts 160 and 164

1. Authorization

I authorize Bluewater Foot & Ankle Specialists to use and disclose the protected health information described below to _____ (individual seeking the information).

2. Effective Period

This authorization for release of information covers the period of healthcare from: _____ to _____
OR ☐ all past, present, and future periods.

I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

Signature →		Name (print)	Date