FOOTCARE, P.A.
PATIENT UPDATE SHEET

NAME: _____

DATE: _____

1. When were you last seen in our office? _____
2. Who is your family physician? _____

   Date last seen: _____
3. Are you being treated by any new doctors? _____

   Who and what health conditions? _____
4. Have you been diagnosed with any new health condition since your last visit to our office?

   _____
5. Have you had any surgeries since you were last seen here? _____
6. What medications are you currently taking? _____
7. Do you have any allergies to drugs/medications? _____
8. What is the nature of your present foot problem? _____
9. Has your address changed since your last visit? _____
10. Has your phone number changed since your last visit? _____
11. Has your insurance company changed? _____
12. Please list your former last name (if applicable). _____

I hereby give **FootCare, P.A.**, permission to evaluate, diagnose, treat and manage my podiatric condition. By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance to your prior consent. This consent is given freely with the understanding that:

1. Any and all records, whether written or oral or in electronic format, are confidential and cannot be disclosed without my prior written authorization, except as otherwise provided by law.
2. A photocopy or fax of this consent is as valid as this original.
3. I may revoke this consent at any time, except where information has already been released. This consent is valid until revoked by me in writing.
4. I have the right to request that the use of my Protected Health Information that is used or disclosed for the purposes of treatment, payment, or health care operations be restricted. **FootCare, P.A.** is not bound by the restriction unless it is in agreement with the restriction.

Signature of Patient or Guardian: _____ **Date:** _____