GREGORY B. MORRIS, DPM, LLC

FOR OFFICE USE ONLY			
Account No	Type	Dr. #	Date

LAST NAME	FIRST NAME	MIDDLE NAME
SEX ☐ M ☐ F / DATE OF BIRTH / SOCIAL SECURITY # / MARITAL STATUS ☐Single ☐Married ☐Divorced ☐Separated ☐Widowed		
PATIENT'S ADDRESS (INCLUDE CITY, STATE AND ZIP CODE)		HOME PHONE
GUARANTOR'S NAME & ADDRESS, IF DIFFERENT (INCLUDE CITY, STATE AND ZIP CODE)		CELL/PAGER
EMPLOYER NAME/ADDRESS		BUSINESS PHONE
SPOUSE'S NAME	SPOUSE'S EMPLOYER	BUSINESS PHONE
EMERGENCY CONTACT NAME/ADDRESS (someone not living with you)		PHONE
REFERRING DOCTOR / PRIMARY CARE DOCTOR	ADDRESS	PHONE NUMBER
ETHNICITY (OPTIONAL)	PREFERRED LANGUAGE (OPTIONAL)	EMAIL ADDRESS

If patient is a CHILD, please complete the following:

PARENT/GUARDIAN'S NAME	RELATIONSHIP TO PT	MARITAL STATUS ☐Single ☐Married ☐Divorced ☐Separated ☐Widowed
HOME PHONE	BUSINESS PHONE	CELL/PAGER / CHILD'S SCHOOL
PERSON(S) WHO MAY AUTHORIZE TREATMENT FOR CHILD		RELATIONSHIP TO PATIENT

INSURANCE INFORMATION

☐ PRIVATE INSURANCE ☐ WORKERS' COMPENSATION ☐ NO-FAULT ☐ TPL

PRIMARY INSURANCE NAME & ADDRESS	SUBSCRIBER NAME	SEX ☐M ☐F	BIRTHDATE
	SOCIAL SECURITY # / EMPLOYER		EFF DATE
Phone: Fax:	MEMBERSHIP# / POLICY# / CLAIM #	GROUP #	COVG CODE
SECONDARY INSURANCE NAME & ADDRESS	SUBSCRIBER NAME	SEX ☐M ☐F	BIRTHDATE
	SOCIAL SECURITY # / EMPLOYER		EFF DATE
Phone: Fax:	MEMBERSHIP# / POLICY# / CLAIM #	GROUP #	COVG CODE
TERTIARY INSURANCE NAME & ADDRESS	SUBSCRIBER NAME	SEX ☐M ☐F	BIRTHDATE
	SOCIAL SECURITY # / EMPLOYER		EFF DATE
Phone: Fax:	MEMBERSHIP# / POLICY# / CLAIM #	GROUP #	COVG CODE

INJURY INFORMATION

DATE OF INJURY/ONSET	CONDITION(S) WE ARE TREATING YOU FOR TODAY
FOR OFFICE USE ONLY:	

AUTHORIZATION TO RELEASE MEDICAL INFORMATION and ASSIGNMENT OF INSURANCE BENEFITS:
I authorize Gregory B. Morris, DPM, LLC, or its representative, to release to my insurance company or its representative any information including the diagnosis and the records of any treatment or examination rendered to me during the period of such medical or surgical care. I hereby authorize that payments for these services be made directly to my physician or supplier.

FINANCIAL AGREEMENT: **I understand that I am financially responsible for all charges whether or not paid by said insurance.** These include deductible, co-payment, cost-share, and/or non-covered benefits. I also agree to pay a late payment fee of 1% a month on any unpaid balance over 90 days old together with reasonable attorney's fees and collection expenses should the account be referred to an attorney or collection agency. I agree to pay a $10.00 processing fee for each returned check.

I certify that the insurance information I have provided is correct. I permit a copy of this authorization to be used in place of the original. This authorization is valid until revoked by me in writing.

Patient/Parent/Guardian Signature _____ Relationship to Patient _____ Date _____

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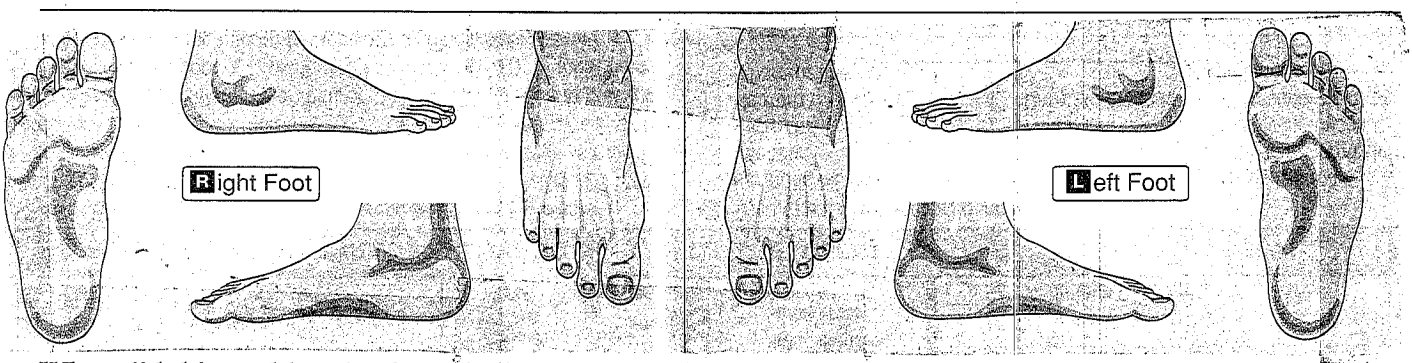
Patient's Name: _____ **Date:** _____

Please indicate on the diagram and in a few brief words, what is your foot or ankle problem?

_____

_____



When did this problem begin and what treatment has been done for it?

_____

_____

Do you have diabetes? YES NO

If Yes, when did you last see your physician? _____

Was this injury a Workman's Compensation or Auto Accident? YES NO

If Yes, Date of Injury: _____ Claim # (If Known): _____

Liability Insurance Company/Adjuster: _____

Address: _____

_____

MEDICARE PATIENTS ONLY, PLEASE READ AND SIGN BELOW

Dear Patient:

Medicare regulations suggest that I, Dr. Gregory Morris, inform you in advance, that some medical services may not be fully covered or reimbursed by Medicare. If in my professional opinion and judgment, the following services are needed in order to provide to you with the highest quality of care, they may not be completely reimbursed by Medicare:

Routine foot care and medical appliances.

Medicare may not reimburse these services for the following reasons: **Non-Covered service.**

_____ _____

Gregory Morris, DPM, AACFAS Date Medicare Patient's Signature Date

GREGORY MORRIS, DPM FACFAS, LINDA HO, DPM
MEDICAL HISTORY AND QUESTIONNAIRE SHEET

FAMILY PHYSICIAN NAME: _____ **DATE LAST SEEN:** _____

PLEASE CIRCLE ANY ILLNESSES OR CONDITIONS YOU HAVE: ARTHRITIS ASTHMA CANCER GOUT DIABETES/TYPE___ HOW LONG___ HEART PROBLEMS HEPATITIS/TYPE___ KIDNEY HIGH BLOOD PRESSURE HIGH CHOLESTEROL POOR CIRCULATIONS PROLONGED BLEEDING STOMACH ULCERS STROKE LIVER/JAUNDICE TUBERCULOSIS OTHER:_____

DIALYSIS: ( ) YES ( ) NO ***IF YES, PLEASE CIRCLE WHICH DAYS:*** (M) (T) (W) (TH) (F)

FAMILY MEDICAL HISTORY:
MOTHER – ALIVE ( ) DECEASED ( ) OF _____
FATHER – ALIVE ( ) DECEASED ( ) OF_____
SIBLING – _____

SMOKING: CURRENT EVERYDAY CURRENT SOMEDAY FORMER HEAVY TOBACCO LIGHT TOBACCO ECIG CHEW TOBACCO NEVER SMOKED

PLEASE LIST ALL MEDICATIONS:

_____
_____
_____

DO YOU HAVE ALLERGIES: ANTIBIOTICS ANESTHESIA LOCAL OR IV ASPIRIN BACTRIM BETADINE CODEINE CORTISONE DEMEROL IODINE IBUPROFEN MORPHINE NSAIDS PENICILLIN (PCN) PERCOCET SEAFOOD/SHELLFISH SULFA-DRUGS OTHERS:

_____

PREVIOUS SURGERY NAME & BODY PART:

_____
_____
_____

I understand that my signature is on file authorizing release of my medical records or any other information required to process insurance forms. I also request payment of medical benefits to Gregory Morris, DPM, FACFAS. I give my permission to physicians to administer treatment and to perform such procedures as may be deemed to the diagnosis and /or treatment of my foot / or ankle conditions.

Signature of Patient/ Parent/ Guardian: _____ Date: _____

GREGORY MORRIS, DPM, FACFAS
PODIATRY – FOOT AND ANKLE SURGERY
LINDA HO, DPM

Phone: 532-3338 Physician Exchange: 524-2575 Fax: 532-3339

Queen's Physician Office Building II
1329 Lusitana Street, Ste. 802
Honolulu, HI 96813

Queen's West Physician Office Building
91-2139 Fort Weaver Rd. Room 303
Ewa Beach, HI 96706

Gregory B. Morris, DPM, FACFAS, LLC is in the process of implementing ePrescribing in our office.

ePriscribing is a federally mandated initiative that requires all physicians to prescribe in this manner by 2011.

ePrescribing software sends prescriptions over the internet to your pharmacy in a safe, secure way, through the same technology used by credit card companies. This helps protect the privacy of your personal information.

ePrescribing software also lets your doctor see important information – like drug interactions and your prescription history.

The benefit to you:

*Less confusion over handwritten prescriptions or unclear phone calls
*Reduced possibility of medical errors
*Less chance of adverse drug reactions
*Fewer trips to drop off at the pharmacy
*A safer, faster, easier way to get your prescription filled

Patient Consent
I agree that Gregory B. Morris, DPM, FACFAS, LLC may request and use my prescription medication history from other healthcare providers or third party pharmacy benefit payers for treatment purposes.

EMAIL: _____

Signature of Patient: _____

Date: _____

Pharmacy of Choice:

Name: _____

Location: _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF USE AND DISCLOSURES OF PROTECTED HEALTH INFORMATION FOR

GREGORY B. MORRIS, DPM, LLC

I have read the Notice of the Uses and Disclosures of Protected Health Information (the "Notice") that is posted in your office. I was informed that I may also obtain a printed copy of the Notice from your receptionist. I hereby acknowledge that I received from Gregory B. Morris, DPM, LLC a copy of the Notice.

PRINT: _____

SIGN: _____

DATE: _____