NEW PATIENT PACKET

Dear Patient,

The office of Dr. Kevin Derickson (Podiatrist - Foot Dr.) looks forward to seeing you at your new patient appointment. Enclosed we are sending you your new patient papers to be filled out **COMPLETELY** prior (before) your appointment. Please bring the papers along with you to your appointment, by filling out the papers before your appointment saves a lot of time and helps the process move a little quicker. We ask that YOU **DO NOT MAIL OR FAX THESE PAPERS** because of personal information on them. Please list all medications along with dosage and milligrams also list the name and location of the pharmacy that you use. If you have any questions before your appointment please do not hesitate to call us.

Sincerely,

Dr. Kevin Derickson

Capital Regional Medical Group
2770 Capital Medical Blvd Suite 200
Tallahassee, FL 32308·
850-878-8235

CAPITAL REGIONAL
MEDICAL GROUP

NEW PATIENT PACKET

Patient Consent Form

Please Read and Sign

I, the undersigned, hereby consent to the following treatment:

- Administration and performance of all treatments
- Administration of any needed anesthetics
- Performance of such procedures as may be deemed necessary and advisable in the treatment of this patient
- Use of prescribed medication
- Performance of diagnostic procedures / tests and cultures
- Performance of other medically accepted laboratory tests that may be considered medically necessary or advisable based on the judgement of the attending physician or their assigned designees

I fully understand that this is given in advance of any specific diagnosis or treatment.

I intend this consent to be continuing in nature even after a specific diagnosis has been made and treatment recommended. The consent will remain in full force until revoked in writing.

I understand that Capital Regional Health may include consent at satellite offices under common ownership.

I, the undersigned, authorize Capital Regional Health Care physicians to use and disclose my information for the purpose of treatment, payment and healthcare operations as described in the Notice of Privacy Practices.

A photocopy of this consent shall be considered as valid as the original.

MEDICARE PATIENTS: I authorize to release medical information about me to the Social Security Administration or its intermediaries for my Medicare claims. I assign the benefits payable for services to Capital Regional Health Care.

I acknowledge that I have been given the Capital Regional Health Care Notice of Privacy Practices.
I understand that if I have questions or complaints that I should contact the Privacy Official.
Patient Initial: _____

I certify that I have read and fully understand the above statements and consent fully and

voluntarily to its contents.

Patient (or Responsible Party) Signature **Date**

CAPITAL REGIONAL MEDICAL GROUP

NEW PATIENT PACKET

Patient Information

☐ Dr. ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Jr. ☐ Sr ☐ Other ☐ Male ☐ Female

Patient's Name (Last) _____ (First) _____ (Middle) _____

Also Known as Name (Last) _____ (First) _____

☐ Married ☐ Widowed Social Security Number _____

☐ Single ☐ Legally Separated Date of Birth _____

☐ Divorced ☐ Other Email Address _____

Phone Numbers Home: _____ ☐ Day ☐ Evening

Cellular: _____ ☐ Day ☐ Evening

Work: _____ ☐ Day ☐ Evening

Pager: _____

May we contact you at work ☐ Yes ☐ No

Address: _____

City, State, Zip (+4) _____

Employment Status: ☐ Employed ☐ Self Employed ☐ Unemployed

☐ Full-Time Student ☐ Part Time Student ☐ Retired

Employer: _____ Occupation: _____

Emergency Contact Name: _____ Phone Number: _____

Relationship to patient: _____

Responsible Party Information

Resp Party Name (Last) _____ (First) _____ (Middle) _____

Also Known as Name (Last) _____ (First) _____

Social Security Number: _____ ☐ Male ☐ Female DOB _____

Email Address _____

Phone Numbers Home: _____ Work: _____

Address: _____

City, State, Zip (+4) _____

Employment Status: ☐ Employed ☐ Self Employed ☐ Unemployed

☐ Full-Time Student ☐ Part Time Student ☐ Retired

Employer: _____ Employer Phone Number: _____

Patient Relationship to Responsible Party _____

CAPITAL REGIONAL MEDICAL GROUP

NEW PATIENT PACKET

Primary Insurance Information

Please Provide your Insurance Card to the Front Desk

Name of Insured _____

Patient Relationship to Insured _____

Insurance Company / Phone Number _____ (____) _____

Subscriber ID (Policy Number) _____ Group ID _____

Effective Date _____

Insured Date of Birth_____ Insurance _____

Company

Address _____

Secondary Insurance Information Please provide your insurance card to the front desk

Name of Insured _____

Patient Relationship to Insured _____

Insurance Company / Phone Number _____ (____) _____

Subscriber ID (Policy Number) _____ Group ID _____

Effective Date _____

Insured Date of Birth_____ Insurance _____

Company

Address _____

I agree that the information supplied on this form is accurate and up-to-date to the best of my knowledge

Patient Signature: _____ Date: _____

CAPITAL REGIONAL MEDICAL GROUP

NEW PATIENT PACKET

PRESCRIPTION ORDER PICK-UP

Prescription Order Pick-up. There may be times when you need a friend or family member to pick-up a prescription order (script) from your physician's office. In order for us to release a prescription to your family member or friend, we will need to have a record of their name. Prior to release of the script, your designee will need to present valid picture identification and sign for the prescription.

_____ (Patient/Representative Initials) I ***wish*** to designate the following individual to pick up a prescription order on my behalf:

Name: _____ Date: _____

Name: _____ Date: _____

_____ (Patient/Representative Initials) I ***do not want to*** designate the anyone to pick up a prescription.

_____ _____

Patient/Parent/Guardian/Patient Representative Signature **Date**

Patient/Parent/Guardian/Patient Representative Name (Printed) _____

Patient Name (Printed): _____ **Date of Birth:** _____

Updated: December 20, 2016 replacing April22, 2016, October 28, 2015, June 12, 2015 & November 21, 2013 version
A photocopy of this consent shall be considered as valid as the original.

CAPITAL REGIONAL MEDICAL GROUP

NEW PATIENT PACKET

Past Surgeries	Dates

Allergies: _____

Vital Signs: Temp _____ Pulse _____ BP _____ Ht _____ Wt _____

	YES	NO		
Do You Smoke?	_____	_____	Packs per day? _____	How Many Years? _____
Have Your Smoked in the past?	_____	_____	When _____	
Do you drink alcohol?	_____	_____	Glasses per day? _____	How Many Years? _____
Have you used alcohol in the past?	_____	_____	When _____	

Medications	Dosage/Times per day taken

Pharmacy – Location _____ Phone _____

CAPITAL REGIONAL MEDICAL GROUP

NEW PATIENT PACKET

Chief Complaint _____ How Long? _____

How did it start?_____ Do you live alone? _____

Please list all of the doctors you are presently seeing: _____

Have you been in good general health lately?			If no explain:
Do you Have a history of?	NO	YES	If Yes explain
Diabetes Do you monitor your blood sugar			
Exposure to TB			
Hypertension			
Chest Pain			
Difficulty Breathing			
Asthma			
Emphysema			
Hepatitis or Jaundice			
Seizure or Convulsion			
Stroke			
Thyroid Disease			
Free Bleeding			
Bruise Easily			
Blood Clots			
On Oxygen at Home			
Pacemaker			
Swelling of Legs/Ankles			
Varicose Veins			
Vision Problems			
Hearing Problems			
Constipation			
Diarrhea			
Black or Bloody Stool			
Stomach Ulcer			
Dialysis			
Urination Problems			
Leg Pain			
Arthritis			
Skin Problems			
Numbness/Tingling			
Depression/Anxiety			
Change in Memory			
Anemia/Blood Disease			
Lupus			
Sickle Cell Disease			
Cancer			
Chemotherapy/Radiation Therapy			

Any additional problems not listed: _____

_____

Patient Signature: _____ Date: _____