EVERGREEN FOOT & ANKLE
Dr. Tina P. Huynh, DPM, AACFAS
6928 B little River Turnpike
Annandale, VA 22003
Phone 703-462-9339 Fax 571-565-3144

New Patient Registration

Date: _____ **Primary Care Doctor:** _____

First Name: _____ **Last Name:** _____ **DOB:** _____ **Age:** _____

Ethnicity: _____ **Gender: M / F** **Marital Status: Single Married Div. Sep Minor** **SSN:** _____

Address: _____

City: _____ **State:** _____ **Zip:** _____ **Home Phone:** _____ **Cell:** _____
Email: _____

Occupation: _____ Employer: _____

Address: _____ Work No. _____

Insurance Information

Primary Insurance: _____ Secondary Insurance: _____

Policy No. _____ Policy No. _____

Subscriber: _____ Subscriber: _____

Employer: _____ Relationship to patient: Self/ Spouse/Parent/Other_____

Emergency Contact

Name: _____ Relationship: _____

Address: _____

Home Phone: _____ Cell Phone: _____

PREFFERED PHARMACY

Name: _____ Address: _____

Phone: _____ City: _____ State: _____ Zip: _____

The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to **Dr. Tina P. Huynh**. I understand that I am financially responsible for any balance that is not covered by my insurance. I also Authorize **Evergreen Foot & Ankle** or insurance company to release any information required to process my claims.

If you are unable to keep the appointment, please contact us within 24 hours to avoid a **$35.00** charge for **NO SHOW** appointment.

I have read and understand all above statement.

Name: _____ Signature: _____ Date: _____

Thank you for choosing Evergreen Foot & Ankle. www.Evergreenfootandankle.com

What is the main reason for your visit today? _____

When did symptoms start? _____ If injury, place & date: _____

When was your last physical exam? _____ Physician's name: _____

Are you under the care of a physician now? YES NO If so, for what reason? _____

Medications:

Please list **all** medications you are taking now. Including vitamins/supplement

Are you allergic to any medication or latex? YES NO If yes, please list them.

History:

Are you a current smoker? YES NO Previous smoker? YES NO How many packs per day? _____

Previous foot surgery? YES NO

Please list any other surgeries: _____

Please circle any past medical history of:

Arthritis Liver disease Bleeding disorders Neurological problems Heart disease

Kidney disorders Stroke High cholesterol Type I Diabetes Type II Diabetes

High Blood Pressure Cancer Respiratory problems Thyroid Disease Anemia HIV

Others _____

Patient consent Treatment:

I _____ (Print name) certify that the above information is accurate to the best of my knowledge. I give permission to Dr. Huynh and associates of Evergreen Foot and Ankle to administer and perform the procedure necessary in the diagnosis and treatment. I understand that a perfect result Is not guaranteed.

_____ _____ _____

Printed name of patient/parent/guardian Signature Date

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Podiatric Medicine	Foot & Ankle surgery	Wound Care/Limb salvage	Sport Medicine

NOTICE OF PRIVACY PRACTICES

As required by the privacy regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPA

Our commitment to your privacy:

Our practice is dedicated to maintaining the privacy of your individually identifiable health information (also called *protected* hea information, or PHI). In conducting our business, we will create records regarding you and the treatment and services we provide you. We are required by law to maintain the confidentiality of health information that identifies you. We also are required by law provide you with this notice of our legal duties and the privacy practices that we maintain in our practice concerning your PHI. By federal and state law, we must follow the terms of the Notice of Privacy Practices that we have in effect at the time.

We may use and disclose your PHI in the following ways:

The following categories describe the different ways in which we may use and disclose your PHI.

Treatment: Our practice may use your PHI to treat you. For example, we may ask you to have laboratory tests (such as blood or urine tests), and we may use the results to help us reach a diagnosis. We may disclose your PHI to other health care providers fo purposes related to your treatment.

Payment: Our practice may use and disclose your PHI in order to bill and collect payment for the services and items you may rece from us. We may disclose your PHI to other health care providers and entities to assist in their billing and collection efforts.

Health care operations: Our practice may use and disclose your PHI to operate our business. As examples of the ways in which w may u se and disclose your information for our operations, our practice may use your PHI to evaluate the quality of care you received from us, or to conduct cost-management and business planning activities for our practice. We may disclose your PHI to other health care providers and entities to assist in their health care operations.

Disclosures required by law. Our practice will use and disclose your PHI when we are required to do so by federal, state or local l

The entities re most often not required to obtain patient consent.

You may refuse to consent to the use or disclosure of your personal health information. Under this law, we have the right to refu to treat you should you choose to refuse your Personal Health Information (PHI).

Confidential communications: You have the right to request that our practice communicate with you about your health and relat issues in a particular manner or at a certain location.

If you have any questions regarding this notice or our health information privacy policies, please ask to speak with our HIPPAA Compliance Officer.

I have read and understand the Notice of Privacy Practices.

_____ _____ _____

Print Name Signature Date