KERNODLE CLINIC PODIATRY DEPARTMENT

JUSTIN A. FOWLER, D.P.M. MATTHEW G. TROXLER, D.P.M TODD CLINE, D.P.M

PATIENT NAME:_____ **PATIENT ID:**_____

DATE OF BIRTH:_____

HAVE YOU TRAVELED OUTSIDE THE U.S. IN THE LAST 21 DAYS?* **(YES) **(NO)**

**WHO IS YOUR PRIMARY CARE PHYSICIAN?* _____

CURRENT PROBLEM

**WHAT KIND OF FOOT PROBLEMS ARE YOU HAVING?* _____

_____

**HOW LONG HAVE YOU HAD THIS PROBLEM?* _____

**ANY PRIOR TREATMENT FOR THIS PROBLEM?* _____

**IF SO PLEASE EXPLAIN:* _____

DRUG ALLERGIES & REACTIONS

DRUG ALLERGY	REACTION

CURRENT MEDICATIONS- PRESCRIPTION OR NON-PRESCRIPTION

NAME & DOSAGE	FREQUENCY	NAME & DOSAGE	FREQUENCY
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

PHARMACY NAME & LOCATION: _____

MEDICAL HISTORY: (CIRCLE ALL THAT APPY) ( ) **ALL NEGATIVE**

ALCOHOL ABUSE	GERD	LUNG CANCER	STROKE
ANEMIA	GOUT	LUPUS	ULCERS
ASTHMA	HEART DISEASE	OSTEOARTHRITIS	
BREAST CANCER	HEPATITIS	PROSTATE CANCER	
COLON CANCER	HIV/AIDS	RHEUMATOID ARTHRITIS	**OTHER:**
COPD	KIDNEY DISEASE	SEIZURES	
DEPRESSION	HYPERTENSION	SICKLE CELL ANEMIA	
DIABETES MELLITUS	HYPERLIPIDEMIA	SLEEP APNEA	

SURGICAL HISTORY: (CIRCLE ALL THAT APPLY) ( ) **ALL NEGATIVE**

	DATE		DATE
APPENDECTOMY		HYSTERECTOMY	
BACK SURGERY		JOINT REPLACEMENT	
CHOLECYSTECTOMY		KNEE REPLACEMENT	
HEART SURGERY		MASTECTOMY	
C-SECTION		PACEMAKER	
HERNIA REPAIR		TONSILLECTOMY	
VASECTOMY		TUBAL LIGATION	

OTHER SURGERY: _____

_____

FAMILY MEDICAL HISTORY: (PLEASE CIRCLE IF ANY RELATIVE HAS HAD ANY OF THE FOLLOWING.)

HEART PROBLEMS	DIABETES	GOUT
LEUKEMIA	STOMACH ULCER	LUPUS
KIDNEY DISEASE	ARTHRITIS	ARTHRITIS
CANCER	BLEEDING DISORDER	MIGRAIN HEADACHES
EPILEPSY	STROKE	THYROID
GOITER	TUBERCULOSIS	TUMOR
GLAUCOMA	SICKLE CELL DISEASE	

OCCUPATION: _____

SOCIAL HISTORY: (PLEASE CIRCLE ONE)

ALCOHOL USE:* **(YES) (NO) **TYPE AND FREQUENCY?*_____

_____

**TOBACCO USE:* (PLEASE CIRCLE ONE)

(CURRENT EVERYDAY) (FORMER SMOKER) (NEVER SMOKER)

DATE QUIT:_____

PACKS/DAY: _____

**SMOKLESS TOBACCO:* (PLEASE CIRCLE ONE)

(CURRENT EVERYDAY) (FORMER USER) (NEVER)

DRUG USE:* (PLEASE CIRCLE ONE) **(YES) (NO)

TYPE & FREQUENCY:_____

Review of Systems

Check box if positive - Otherwise negative

General Health Status
- ☐ Fever
- ☐ Sweats
- ☐ Fatigue
- ☐ Chills
- ☐ Weight Loss
- ☐ Weight Gain

Neuro
- ☐ Headaches
- ☐ Numbness: Location_____
- ☐ Tingling: Location_____
- ☐ Weakness: Location_____
- ☐ Seizures

Mental Health
- ☐ Sleep pattern abnormality
- ☐ Depression
- ☐ Anxiety

Eyes
- ☐ Blurred vision
- ☐ Changing vision

Ears/Nose/Allergy
- ☐ Ear Pain
- ☐ Hearing Loss
- ☐ Congestion

Neck
- ☐ Swelling
- ☐ Masses
- ☐ Pain
- ☐ Limited movement

Cardiac
- ☐ Chest pain
- ☐ Abnormal pulse
- ☐ Swelling in legs and feet

Respiratory
- ☐ Cough
- ☐ Shortness of breath
- ☐ Wheezing

GI
- ☐ Nausea
- ☐ Vomiting
- ☐ Intolerance to NSAIDS (example: Aleve, ibuprofen, Motrin, or aspirin)
- ☐ Constipation
- ☐ Diarrhea
- ☐ Abdominal pain
- ☐ Bloody or dark stools

GU
- ☐ Urinary frequency
- ☐ Frequent urination at night
- ☐ Painful urination
- ☐ Blood in urine
- ☐ Difficulty urinating

Endocrine
- ☐ Fatigue
- ☐ Heat intolerance
- ☐ Cold intolerance

Hematologic
- ☐ Easy bruising
- ☐ Easy bleeding
- ☐ Difficulty stopping bleeding
- ☐ Blood clots

Musculoskeletal
- ☐ Joint pain
- ☐ Back Pain
- ☐ Muscle pains

Skin
- ☐ Rash
- ☐ Changing Mole
- ☐ Itching
- ☐ Slow Healing wounds

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Duke Health

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Patient Label
Patient Name
Medical Record #
Account #
Date of Birth

Release From:

☐ Duke University Hospital ☐ Duke Raleigh Hospital ☐ Duke Regional Hospital ☐ Duke Eye Center ☐ Davis Ambulatory Service Center (DASC)

☐ Duke Primary Care (specify location:_____) ☒ Private Diagnostic Clinic (PDC) (Specify name: Kernodle Clinic)

☐ ALL DHE Entities ☐ Other (describe): _____

Action Requested:

☐ Provide a copy of my Health Information to: ☐ I request to view my Health Information onsite (I do not want a copy)

☐ Discuss my Health Information with:

Name_____ Phone_____ Fax _____

Address _____
Street City State Zip

How would I like the records or Health Information to be released? (for other options call #919-684-1700)

FORMAT (check one): ☐ Paper copy ☐ Electronic copy (CD) ☐ Electronic copy (flash drive) ☐ MyChart

DELIVERY: ☐ Mail ☐ Fax ☐ In Person Pick up (NAME OF PERSON) _____

☒ Oral Communication ☐ Encrypted Email: (enter address clearly)_____

Purpose:

☐ Continuation of Care ☐ Insurance ☐ Legal ☐ Personal ☐ Other (specify)_____

Treatment Date(s):

☐ Treatment dates from_____to_____ (Please be specific) OR ☐ ALL Treatment Dates

Information to be Released: (check reports below)

☒ ENTIRE RECORD ☐ Summary Information (Discharge Summary, Operative Notes/ Procedure Notes, Radiology, Pathology, Laboratory, EKG, ED Notes, Clinic Visits, Consults)	☐ History & Physical ☐ Radiology Reports ☐ Laboratory Reports ☐ Pathology Reports ☐ Clinic Notes (Ambulatory ☐ Operative Report	☐ ED Record ☐ Discharge Summary ☐ Immunization Records ☐ PT/OT Notes	☐ Discharge Instructions ☐ Clinic Notes (Ambulatory Progress Notes) ☐ Other (specify)

☐ **Information contained in the Patient's medical record related to psychiatric and/or psychological diagnosis, status, symptoms, prognosis, and treatment to date. (May require physician approval.)**

☐ **Information contained in the Patient's medical record related to treatment for alcohol and/or drug abuse.**

I Understand That:

- ***The information to be released may include a diagnosis or reference to the following conditions: sickle cell anemia, genetic testing, acquired immune deficiency syndrome (AIDS) or human immunodeficiency virus (HIV).***
- Without my express revocation, this Authorization will automatically expire one year from the date signed below, unless I request an expiration date less than one year.
- I may **revoke** this Authorization in writing at any time, except to the extent that action has already been taken to comply with it. Such revocation shall not affect disclosures prior to the revocation to the extent that this Authorization was relied upon for such disclosures made prior to the revocation.
- Information disclosed pursuant to the Authorization may be subject to redisclosure by the recipient and may no longer be protected by the HIPAA Privacy Rule.

Signature: My signature is required to validate this Authorization. This Authorization is voluntary. If I do not sign this Authorization, Duke University, Duke University Health System, and the Private Diagnostic Clinic, PLLC will still provide treatment and seek payment for services provided. According to the North Carolina General Statutes, Health Information Management may charge for copies of medical records. **This Authorization will expire on** _____.

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X_____ X_____ _____
Signature of Patient/Guardian/Personal Representative Date Relationship (parent, guardian, etc.)

_____
Witness

If you are not the patient, you MUST attach documentation of your authority to act on behalf of the patient. (other than parent).

Send request to the applicable entity address or fax listed below or **email to: ROI-requestor3@dm.duke.edu. For questions: 919-684-1700**

Duke University Hospital, DASC, DPC clinics, PDC clinics H.I.M. Box 3016 Durham, NC 27710 Fax: 919-620-5165	**Duke Raleigh Hospital** H.I.M. 3301 Executive Drive MOB5, 2nd floor Raleigh, NC 27609 Fax: 919-620-5165	**Duke Regional Hospital** H.I.M. 3643 N Roxboro Road Durham, NC 27704 Fax: 919-620-5165	**Duke Eye Center** Email: EyeCente-MedicalRecords@dm.duke.edu H.I.M. PO Box 101005 Durham, NC 27710 Fax: 919-681-1013 • Phone: 919-684-3588

Kernodle Clinic Podiatry Department

Policy Changes 2017

Due to rising costs and a decline in reimbursement fees from insurance companies, it has become necessary to institute a strict policy regarding no shows and late cancellations.

1. A 24 hour cancellation notice is required if you are unable to keep your appointment. Office phone hours are 8am – 5pm Monday – Friday. Day of visit cancellations and no-shows may be charged a fee of $25.00.
2. Co-pays are an agreement you have with your insurance company. We are obligated to collect the co-pay at the time of the visit. Should you not be able to pay your co-pay, your appointment may need to be rescheduled.
3. If you arrive more than 15 minutes late, your appointment may need to be rescheduled.
4. Repetitive no-shows and/or late cancellations may lead to discharge from the Podiatry department.
5. No refills will be provided for patients on a walk-in basis. Patients must call their pharmacy for their refills.
6. Disability paperwork must be dropped off. We require at least 72 hours for completion of this paperwork and a $10.00 fee will be expected at the time of pick up.

We would appreciate your cooperation and certainly appreciate your confidence in us to provide your care. Thank you.

Print name: _____

Signature: _____