PATIENT MEDICAL HISTORY

Have you had or do you have any of the following conditions?

- ☐ Heart Problems
- ☐ Hepatitis A or B
- ☐ Vision Problems
- ☐ Pacemaker
- ☐ Hypertension
- ☐ Hepatitis C
- ☐ Parkinson Disease
- ☐ Seizures
- ☐ Vascular Disease
- ☐ HIV Positive
- ☐ Alzheimer Disease
- ☐ Hearing Loss
- ☐ Stroke
- ☐ Rheumatoid Arthritis
- ☐ Psychiatric
- ☐ Pregnant
- ☐ Diabetes
- ☐ Alcoholism
- ☐ MRSA
- ☐ Kidney Disease
- ☐ Osteoarthritis
- ☐ Osteoporosis
- ☐ Pulmonary Disease
- ☐ Obesity

List any known allergies: _____

_____

Currently taking medications? YES NO

If so, Please list: _____

_____

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ACKNOWLEDGEMENT OF RECEIPT - NOTICE OF PRIVACY PRACTICES

I certify that I, _____, have received and read a copy of the **Orthotic & Prosthetic Center, Inc. Notice of Privacy Practices**. The **Notice of Privacy Practices** describes the types of uses and disclosures of my protected health information that might occur in my treatment, payment of my bills or in the performance of the **Orthotic & Prosthetic Center, Inc**. health care operations. The **Notice of Privacy Practices** also describes my rights and the **Orthotic & Prosthetic Center, Inc.** duties with respect to my protected health information. The **Notice of Privacy Practices** is posted in the patient waiting area.

The **Orthotic & Prosthetic Center, Inc**. reserves the right to change to privacy practices that are not described in the **Notice of Privacy Practices**. I may obtain a revised copy of the **Notice of Privacy Practices** by calling the office and requesting a revised copy be sent in the mail, or asking for one at the time of my next appointment.

Signature of Patient or Personal Representative: _____

Printed Name of Patient or Representative: _____

Description of Personal Rep's Authority: _____

Date: _____

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