Welcome to Our Office!!!

Legal Name: _____**Today's Date**: _____
First Ml Last

Birth Date: _____ **Age:** _____ **Male** _____ **Female** _____ **SS#** _____

Address: _____ **APT/PO Box**:_____

City: _____**State:** _____ **ZIP Code**: _____

Home Ph#: _____**Cell #**: _____**Work #**: _____

Best Number to contact you During Normal Business Hours: Home Mobile Work

Appointment Reminder Preference: Phone Call Text E-Mail None

E-Mail Address: _____ **Ok to send PHI via email, text, and voicemail**? Yes No

Responsible Party: _____ **Relationship:** _____

Address (if different from patient): _____

EMERGENCY CONTACT: _____Relationship: _____

Home Phone: _____ Mobile: _____

HOW DID YOU HEAR ABOUT THE PRACTICE? (circle one)

Internet/Google Friend/Family Social Media Insurannce Other Dr. Referral _____

HEALTH INSURANCE INFORMATION:

Policy Holder Name (If different than patient): _____

Policy Holder Birth Date (If different than patient): _____**Relationship:** _____

Primary Insurance Company Name: _____

Does your plan require a referral to see a specialist? Yes No

Second Insurance (if applicable):

Policy Holder Name (If different than patient): _____

Policy Holder Birth Date (If different than patient) : _____Relationship: _____

Primary Insurance Company Name: _____

HIPAA COMPLIANCE:

May we mail paper correspondence to your home address? Yes / No

May we leave a detailed message at your home number? Yes / No

May we leave a detail message via Voice Mail or Text on cell phone? Yes / No

May we send detailed e-mail? Yes / No

May we leave detailed messages at your work number? Yes / No / Not applicable

With whom, may we leave information regarding appointments, accounts, test results and/or surgery information?

Name Relationship Phone Number

Name Relationship Phone Number:

I certify the information provided on this form is correct to the best of my knowledge. I also understand that I am financially responsible for all charges whether covered by insurance or not. I agree to be held responsible for collection processing fees, which may be added to my account if collection action occurs. I authorize the release of medical information necessary to process claims. I authorize the release of medical information to my primary care physician and to any outside facility that is assisting with my care, such as physical therapy, MRI facilities, hospitals and ambulatory surgery centers.

I certify that I have been given the opportunity to review the regulations on Patient Privacy Laws in the form of the HIPAA outline provided by my physician at Central Ohio Comprehensive Foot Care/Delaware Podiatry Center.

PATIENT NAME (Print): _____

SIGNATURE: _____ DATE: _____
If minor, parent or guardian please sign.

IMPORTANT OFFICE POLICIES

MEDICAL INFORMATION

I authorize *Central Ohio Comprehensive Foot Care, LLC/ Delaware Podiatry Center, LLC. to release the medical records concerning my son/daughter/self to any physician, hospital, or agency involved in the care of the patient listed.

ASSIGNMENT OF MEDICAL BENEFITS

I authorize my insurance carrier to assign all surgical and or medical benefits, if applicable, to the appropriate physician. I also authorize release of medical information necessary to process all medical insurance claims. It is your responsibility to inform the office of any insurance changes. In the event you do not do so you will be responsible for all charges incurred. *Knowingly providing insurance information that is expired/terminated is considered insurance fraud. Please make sure we have your correct current insurance information.*

PAYMENT POLICY

Co-payments are to be collected at the time services are received. We accept cash, checks, Visa and MasterCard. All medical services provided are directly charged to the patient or responsible party. If our physician is contracted with your insurance carrier, we will accept their negotiated rate for the charges billed. However, you will be responsible for any balance deemed patient responsibility/non-payable/non-covered by your insurance and billed accordingly. Payment is expected in full upon receipt of statement or payment arrangements must be made with our billing office. There is a **service fee of $45.00 for all returned checks**. This is not payable by your insurance company.

CANCELLATION POLICY

Our office requests that if an appointment needs to be cancelled that we receive notice no later than 4 hours prior to the appointment. ***We reserve the right to charge $50.00 for a "no show" appointment***, to be collected on or before your next appointment.

REFERRAL POLICY

I understand that it is my responsibility to obtain a referral through my primary care physician's office if required by my insurance company. Failure to do so will result in charges being billed directly to myself.

I HAVE READ, UNDERSTAND, AND AGREE TO ABIDE BY THE ABOVE RELEASE OF MEDICAL INFORMATION, PAYMENT, AND OTHER OFFICE POLICIES.

Please Read and Sign:

I hereby authorize my insurance benefits to be paid directly to ***Comprehensive Foot Care/Delaware Podiatry Center**. I understand and am responsible for all charges including my added costs incurred due any effort to collect for services rendered. I realize I am responsible to pay for non-covered services and I hereby authorize the release of pertinent medical information to insurance carriers.

Print Name: _____

Signature of Responsible Party: _____ **Date:** _____

*** Central Ohio Comprehensive Foot Care, LLC and Delaware Podiatry Center, LLC are separate entities.**

REASON for VISIT

Please list your present foot or ankle concerns, problems, or symptoms: _____

_____

MEDICAL HISTORY

When was your last physical exam? _____
Primary Doctor (*First and Last*): _____ **Date last seen:** _____
Pharmacy Name: _____ **Location:** _____
Pharmacy Phone #: _____**May we import your medications from the pharmacy? Yes No**

Height: _____ Weight**:** _____ **Shoe Size:** _____

Are you currently under medical treatment? ……Yes No
Please describe: _____

_____

Have you ever had any serious illnesses? Yes No

_____

Have you had any operations? ……..Yes No
Please describe: _____

_____

Please list your medications you are taking: _____

_____

_____

Do you have a living will or Durable Power of Attorney? Yes No
Do you smoke?..... Yes No
(If yes) _____ # of years _____ # packs per day
Previously Smoked Yes No
Do you use alcohol? ……. Yes No
Do you use illicit drugs? ……..… Yes No

Have you had any allergic reactions to the following:

Local Anesthetics (e.g., Novocain)	Yes	No
Penicillin	Yes	No
Antibiotic _____	Yes	No
Sulfa Drugs	Yes	No
Barbiturates	Yes	No
Sedatives	Yes	No
Aspirin	Yes	No
Latex	Yes	No
Other	Yes	No

Please describe: _____

_____

Women Only:
Have you ever been pregnant? Yes No
If yes, how many pregnancies? _____

Check any of the following you have or had a problem with:

- o Anemia
- o Arthritis
- o Asthma
- o Back Problem
- o Bleeding Tendency
- o Blood Clots
- o Cancer
- o Chicken Pox
- o Circulation
- o Congenital Heart Lesions
- o Diabetes
- o Emotional / Psychiatric Disorder
- o Frequent Infections
- o Glaucoma
- o Gout
- o Healing
- o Heart Disease
- o Heart Murmur
- o High Blood Pressure
- o Infectious Disease (Hepatitis, MRSA,HIV,TB, etc.)
- o Low Blood Pressure
- o Kidney Disease
- o Liver
- o Measles
- o Migraines
- o Mitral Valve Prolapse
- o Mumps
- o Neurological Disorder
- o Pacemaker
- o Respiratory Disease
- o Rheumatic Fever
- o Scarlet Fever
- o Shortness of Breath
- o Skin Rash
- o Sleep Apnea
- o Stroke
- o Thyroid
- o Stomach Ulcers
- o Other:

_____

Family (blood relative) History: (Parent, Grandparent, Sibling)

Cancer _____

Diabetes _____

Heart Disease _____