PATIENT INFORMATION FORM

Welcome to our office. Please take a few minutes to complete both sides of this form so that we may have this information for our records.

NAME:____ BIRTH DATE:______________________DATE:________________

ADDRESS:____CITY:________________________ZIP:_________________

TELEPHONE:(HOME)_____________________________(CELL):_________________________SEX:_______WEIGHT:_________

EMAIL:_____________________________________ HOW WOULD YOU PREFER TO BE CONTACTED: CELL HOME WORK

SOCIAL SECURITY#_________________________DRIVER'S LICENSE#__________________________MARITAL STATUS:_____

BRIEFLY DESCRIBE YOUR FOOT PROBLEM:____

____

PLEASE LIST ANY OTHER FOOT COMPLAINTS:____

____

HAVE YOU SEEN A PODIATRIST FOR FOOT CARE BEFORE?__________IF SO, FOR WHAT?_____________________________

____

NAME & ADDRESS OF FAMILY PHYSICIAN: ____

____

PLEASE LIST ANY MEDICAL PROBLEMS FOR WHICH YOU ARE CURRENTLY BEING TREATED:_________________________

____

PLEASE LIST ANY MEDICATIONS YOU ARE CURRENTLY TAKING:____

____

PLEASE LIST ANY SURGERIES YOU HAVE HAD:____

____

ARE YOU ARE YOU ALLERGIC TO:
ASPIRIN?______IODINE?_______PENICILLIN?_______ADHESIVETAPE?______NOVACAINE?____OTHER?________________

WHOM MAY WE CONTACT IN CASE OF EMERGENCY?

NAME:____PHONE:____

OTHER INFORMATION WE SHOULD KNOW?____

____

HOW DID YOU FIND OUT ABOUT OUR OFFICE:____

STANDARD FINANCIAL FORM

INSURANCE COMPANY:____

ID#____GROUP#____
(For your convenience, we will verify your insurance benefits)

EMPLOYMENT: (SELF) (Parent, if minor) (SPOUSE)

OCCUPATION:____________________________________ OCCUPATION:_____________________________________

EMPLOYER:_______________________________________ EMPLOYER:_______________________________________

ADDRESS:____ ADDRESS:____

____ ____

PHONE:____ PHONE:____

Services not covered by insurance will be paid for in the following manner:

CASH_______CHECK_______MASTERCARD_______VISA________AMERICAN EXPRESS_______OTHER_______________________________

FINANCIAL AGGREEMENT

We find written communication with you avoids misunderstandings. Please feel free to discuss any questions or uncertainties you may have either now or in the future.

GENERAL POLICY: It is our policy that fees for services are due and payable at the time they are rendered. (See above payment options.) Special needs, however, are understood by us. Patients requiring special financial arrangements should speak to the doctor. He is the only person who can approve a special payment plan.

CONTRACTED INSURANCE PLANS: We do have contracts with a majority of insurance plans. Our policy regarding any contracted plans is that coverage eligibility must be verified prior to our agreement to wait for payment of the insurance portion for covered services. Unfortunately, if we are unable to verify your coverage prior to your initial visit, fees for services must be handled as per our GENERAL POLICY. Once insurance coverage is verified, we will be happy to submit a claim to your insurance for them to handle payment of the insurance portion of covered services. You will be responsible for any co-payments, outstanding deductible, estimated percentage of other services, and any non-covered services for which the insurance will not pay at the time these services are rendered. A credit card imprint guaranteeing final payment to be used at the conclusion of treatment can be obtained prior to anticipated extended treatment.

OTHER INSURANCE PLANS: Our policy regarding non-contracted insurance plans is that coverage eligibility must be verified prior to our agreement to wait for payment of the insurance portion for covered services. Unfortunately, if we are unable to verify your coverage prior to your initial visit, fees for services must be handled as per our GENERAL POLICY. Once verified, as a courtesy to you, we will be happy to submit a claim to your insurance for them to handle payment of the insurance portion of covered services. You will be responsible for any co-payments, outstanding deductible, estimated percentage of other services, and any non-covered services for which the insurance will not pay at the time these services are rendered. Please understand that you remain ultimately responsible for all debts incurred in our office and must remit payment for any unpaid balances not reimbursed by other coverage. A credit card imprint guaranteeing final payment to be used at the conclusion of treatment can be obtained prior to anticipated extended treatment.

APPOINTMENT NO-SHOW POLICY: Your appointment time is reserved for you. If you find the time becomes inconvenient, kindly call at least four (4) hours before your appointment time. This will allow us time to adjust our schedule. Repeated cancellations without notification may result in a cancellation fee being charged.

Thank you for taking the time to read and complete this form. Please sign and date this form as having been understood and agreed to.

SIGNATURE:____DATE:________________

Thank You For Completing This Form