FOOT DOCTORS, PSC

for office use only: AMS # _____
DPM: Ford or Towarnicki (circle one)

☐ St. Matthews ☐ U of L

PATIENT INFORMATION

Patient _____
FIRST MIDDLE LAST
Address _____
Street Apt.
_____
City State Zip
Email _____
Home Phone _____ Cell _____
Sex: ☐ M ☐ F Age ____ Birthdate _____
Patient SS # _____
Occupation _____
Employer _____
Employer Address _____
Employer Phone _____
Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced
Spouse's Name _____
SS# _____ Birthdate _____
Spouse's Employer _____
Address _____
Employer Phone _____
Primary Care Physician _____
Last Visit _____
Address _____
Phone _____
Whom may we thank for referring you? _____
Ethnicity: _____
Language: _____

RESPONSIBLE PARTY INFORMATION
(if different from patient)

Name _____
SS # _____ DOB _____
Address _____
Home Phone _____ Work _____ Ext ____

IN CASE OF EMERGENCY

Name _____
Address _____
Home Phone _____ Work _____ Ext ____
Relationship to Patient _____

INSURANCE

Who is responsible for this account? _____
Relationship to Patient _____
Insurance Co. _____
Group # _____ ID # _____
Is patient covered by additional insurance? ☐ Yes ☐ No
Subscriber Name _____
Birthdate _____ SS# _____
Relationship to Patient _____
Insurance Co. _____
Group # _____ ID # _____
Do you need a referral? _____
Do you have a copay? _____

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage with _____ and assign directly to Foot Doctors, PSC all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

_____
Responsible Party Signature

_____ _____
Relationship Date

MEDICARE AUTHORIZATION

I request that payment of authorized benefits be made to Foot Doctors, PSC for any services furnished me by that physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge of determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

_____ _____
Beneficiary Signature Date

PODIATRIC HISTORY

What is the chief complaint for which you came to be treated? (Include foot, ankle, knee, thigh, and hip complaints.)

_____
_____
_____
_____

Location (specify which foot / ankle and what part of foot / ankle):

_____
Example: Right, Left or Both

How long have you had a problem with your foot / ankle? _____

When did it start? _____

What is the cause of the problem?

_____

What treatment(s) have been tried?

_____
_____

Have you ever been to a Podiatrist before?
☐ Yes ☐ No

If yes, please list.

Name _____

Last visit _____

Is there any personal or family history of diabetes? ☐ Yes ☐ No

Cigarette / Tobacco use _____

How much do you smoke? _____

What do you smoke? _____

Do you drink alcohol? ☐ Yes ☐ No

How much do you drink? _____

Height: _____

Weight: _____

Shoe size: _____