North Eastern Ohio Podiatry Group, LLC

WELCOME

PATIENT INFORMATION

DATE _____/_____/_____

PATIENT'S NAME _____

ADDRESS _____

_____

_____
CITY STATE ZIP

SEX: M / F AGE _____ BIRTHDATE _____

MARITAL STATUS: __ SINGLE __ MARRIED __ WIDOWED

__ SEPARATED __ DIVORCED

ETHNICITY: _____

PREFERRED LANGUAGE: ENGLISH / _____

PATIENT'S SOCIAL SECURITY #_____-_____-_____

OCCUPATION_____

EMPLOYER _____

EMPLOYER ADDRESS _____

_____

WHO REFFERRED YOU? Another Dr. ___ Insurance _____

Cleveland Clinic / Hospital Help Desk _____ Friend / Family ___

Direct Mailing ____ ER _____ Internet / Google etc. _____

PHONE NUMBERS

HOME: _____

CELL _____

OK TO LEAVE MESSAGES: YES / NO?

BEST TIME AND PLACE TO REACH YOU _____

EMERGENCY CONTACT:

NAME _____ RELATIONSHIP _____

PHONE _____

WHOM MAY WE CONTACT REGARDING YOU / PATIENT?

_____

CAN MESSAGE BE LEFT WITH THEM: YES / NO?

INSURED INFORMATION

PATIENT - PRIMARY HOLDER OF THE INSURANCE: YES / NO

PRIMARY CARD HOLDER FOR PATIENT'S INSURANCE (NAME):

_____

RELATIONSHIP TO PATIENT _____

GUARANTOR'S DATE OF BIRTH ____/_____/_____

GUARANTOR'S PHONE # _____

GUARANTOR'S ADDRESS _____

_____

_____
CITY STATE ZIP

PATIENT'S LEGAL GUARDIAN / POA:

_____

SIGNATURE ON FILE

- I AUTHORIZE USE OF THIS FORM ON ALL MY INSURANCE SUBMISSIONS.
- **I ACKNOWLEDGE THAT I WAS PROVIDED A COPY OF THE NOTICE OF PRIVACY PRACTICES AND THAT I HAVE READ (OR HAVE THE OPPORTUNITY TO READ IF I SO CHOSE) AND UNDERSTOOD THE NOTICE.**
- I AUTHORIZE RELEASE OF INFORMATION TO ALL MY INSURANCE COMPANIES.
- I AUTHORIZE MY DOCTOR TO CONTACT MY CLOSEST FAMILY MEMBERS
- IN THE CASE OF COMMUNICATION BREAKDOWN BETWEEN ME AND MY DOCTOR'S OFFICE, AND TO INFORM THEM OF MY CONDITION IF DEEMED NECESSARY.
- I UNDERSTAND THAT I AM RESPONSIBLE FOR MY BILL.
- I AUTHORIZE MY DOCTOR TO ACT AS MY AGENT IN HELPING ME OBTAIN PAYMENT FROM MY INSURANCE COMPANIES.
- I AUTHORIZE PAYMENT DIRECT TO MY DOCTOR.
- I PERMIT A COPY OF THIS AUTHORIZATION TO BE USED IN PLACE OF THE ORIGINAL.

FIRST NAME (Print) _____ M.I. _____

LAST NAME _____

SIGNATURE_____DATE _____

STATEMENT TO PERMIT PAYMENT OF MEDICARE BENEFITS TO PROVIDER PHYSICIAN

I CERTIFY THAT THE INFORMATION GIVEN BY ME IN APPLYING FOR PAYMENT UNDER TITLE XVIII OF THE SOCIAL SECURITY ACT IS CURRENT. I AUTHORIZE ANY HOLDER OF MEDICAL OR OTHER INFORMATION ABOUT ME TO RELEASE TO THE HEALTH CARE FINANCE ADMINISTRATION OR ITS INTERMEDIARIES OR CARRIERS ANY INFORMATION NEEDED FOR THIS OR A RELATED MEDICARE CLAIM.

I REQUEST THAT PAYMENT OF AUTHORIZED BENEFITS BE MADE ON MY BEHALF. I ASSIGN THE BENEFITS PAYABLE FOR MEDICARE-COVERED SERVICES TO THE PHYSICIAN OR ORGANIZATION FURNISHING THE SERVICES OR AUTHORIZE SUCH PHYSICIAN OR ORGANIZATION TO SUBMIT A CLAIM TO MEDICARE FOR PAYMENT.

PATIENT'S SIGNATURE: _____ DATE: _____

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

_____

_____

_____

How long have you had this problem? _____

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
Cancer? ☐ Yes ☐ No

Cigarette/ Tobacco use/ Per Day

_____Years smoked _____

Caffeine? _____ Alcohol? _____

Athletic activities in which you participate (please list and indicate frequency)

_____

If injury, is it work / accident / sports related?

See a Pain Management provider: Yes / No?

Please indicate which foot problems you now have or have had in the past.

Ankle Pain	☐Yes	☐No
Athlete's Foot	☐Yes	☐No
Bunions / Toe Pain	☐Yes	☐No
Corns and Calluses	☐Yes	☐No
Numbness in Feet or Leg	☐Yes	☐No
Flat Feet	☐Yes	☐No
Foot or Leg Cramps	☐Yes	☐No
Heel Pain	☐Yes	☐No
Ingrown Toenails	☐Yes	☐No
Plantar Warts	☐Yes	☐No
Swelling in Ankles or Feet	☐Yes	☐No
Skin Rash / Irritation	☐Yes	☐No
Wound(s)	☐Yes	☐No
Joint Pain / Gout	☐Yes	☐No

MEDICAL HISTORY

AIDS/HIV	☐Yes	☐No
Anemia	☐Yes	☐No
Angina	☐Yes	☐No
Arthritis	☐Yes	☐No
Artificial Heart Valves Or Joints/Implants	☐Yes	☐No
Asthma	☐Yes	☐No
Back Problems	☐Yes	☐No
Bleeding Disorders	☐Yes	☐No
Cancer	☐Yes	☐No
Chemotherapy	☐Yes	☐No
Chemical Dependency	☐Yes	☐No
Chest Pain	☐Yes	☐No
Chronic Diarrhea	☐Yes	☐No
Circulatory Problems	☐Yes	☐No
Diabetes	☐Yes	☐No
Ear Problems	☐Yes	☐No
Easy Bleeding/Blood thinners	☐Yes	☐No
Epilepsy	☐Yes	☐No
Eye Problems	☐Yes	☐No
Fainting	☐Yes	☐No
Foot/Leg Ulcers	☐Yes	☐No
Gastric Ulcers/Bleeds	☐Yes	☐No
Gastritis	☐Yes	☐No
Gout	☐Yes	☐No
Headaches	☐Yes	☐No
Heart Disease	☐Yes	☐No
Heart Attacks	☐Yes	☐No
Hemophilia	☐Yes	☐No
Hepatitis or Jaundice	☐Yes	☐No
High Blood Pressure	☐Yes	☐No
Immunosuppression	☐Yes	☐No
Kidney Problems	☐Yes	☐No
Liver Disease	☐Yes	☐No
Low Blood Pressure	☐Yes	☐No
Nervous Problems	☐Yes	☐No
Malnutrition	☐Yes	☐No
Phlebitis	☐Yes	☐No
Psychiatric Care	☐Yes	☐No
Radiation Treatment	☐Yes	☐No
Rash	☐Yes	☐No
Respiratory Disease	☐Yes	☐No
Rheumatic Fever	☐Yes	☐No
Shortness of Breath	☐Yes	☐No
Sinus Problems	☐Yes	☐No
Special Diet	☐Yes	☐No
Stroke	☐Yes	☐No
Swollen Neck Glands	☐Yes	☐No
Thyroid problems	☐Yes	☐No
Tuberculosis	☐Yes	☐No
Ulcers	☐Yes	☐No
Varicose Veins	☐Yes	☐No
Venereal Disease	☐Yes	☐No
Weight Loss, unexplained	☐Yes	☐No

Surgery History _____

Other Hospitalizations _____

Primary Physician _____ Last visit date _____

Are you now, or have you been, under any other doctor's care for any reason over the past two years? ☐Yes ☐No

If Yes, please explain _____

Pharmacy:_____Phone #_____Address:_____

Rx, over-the-counter medications, and vitamins _____

_____

ALLERGIES

☐ Adhesive/Tape	☐ Local Anesthetics
☐ Anticoagulant Therapy	☐ Novocain
☐ Aspirin	☐ Penicillin
☐ Codeine	☐ Seafood
☐ Demerol	☐ Sulfa
	☐ Iodine/Betadine

Others

- To the best of my knowledge, I have answered the questions on this form accurately. I understand that providing incorrect information could be dangerous to Patient's health. I understand that it is my responsibility to update this office on any changes in the future.
- **I also agree to treat all physicians, staff, and fellow patients with dignity, respect, and harassment-free.**

Patient's Signature _____ Date _____