WESTMORELAND FOOT & ANKLE

Welcome to our practice!

In order for us to serve you today with your foot care needs and effectively bill your insurance carrier, please fill out this form completely. Thank you in advance.

Patients legal name:_____
FIRST MIDDLE LAST

Preferred name, if different:_____Sex: Male Female

Date of Birth: _____Social Security number:_____
MM/DD/YYYY

I.PATIENT CONTACT INFORMATION: CHECK IF YOU DON'T HAVE

Email:_____ ☐

Can we send you email notifications about upcoming appointments? Yes No

Mobile phone:_____ ☐

Home phone:_____ ☐

Work phone:_____ ☐

Preferred method of communication: email mobile phone home phone work phone

Address:_____
STREETADDRESS CITY STATE ZIP

II. PAYMENT INFORMATION: ☐CHECK HERE IF YOU ARE SELF PAY AND HAVE NO MEDICAL INSURANCE, then skip this section.

PRIMARY INSURANCE:

Insurance company name:_____

Group ID:_____

Effective date:_____

Relationship of card holder to insured: (circle one)

Self child spouse other

Copay (specialist):$ _____

SECONDARY INSURANCE:

Insurance company name:_____

Group ID:_____

Effective date:_____

Relationship of card holder to insured: (circle one)

Self child spouse other

Copay (specialist):$_____

IMPORTANT!! *If the patient is a child or dependent, or the insurance holder is your spouse, the person who carries the insurance for the patient referred to as your guarantor. We need certain information below for guarantors. If you are not sure, please provide this info anyway. If we do not have it, it can delay processing or reject your insurance claim:

Patient's relationship to guarantor: (circle one) self spouse child other

Guarantor info:_____
FIRST NAME LAST NAME STREET ADDRESS CITY STATE ZIP

_____ MALE FEMALE
DOB:MM/DD/YYYY SEX (CIRCLE) SOCIAL SECURITY NUMBER PHONE NUMBER

III. DEMOGRAPHIC INFORMATION:

Is the patient: (circle) Hispanic/latino non-hispanic/latino I decline to answer

My preferred language is: ☐English ☐Other:_____

What is the patient's race: (circle) American Indian or Alaska Native Asian Black or African American

Native Hawaiian or Pacific Islander White Decline to specify

Who is your primary care/family doctor? _____ Date last seen _____

_____
STREET ADDRESS CITY STATE ZIP PHONE NUMBER FAX NUMBER

Who is your emergency contact/next of kin?_____
FIRST NAME LAST NAME PHONE NUMER

What is your relation to this person?_____

Past Medical History: *circle those pertaining to you*

NONE	Anemia	Anxiety
Arthritis	Asthma	Cancer
Dementia	Depression	Diabetes
Drug Abuse	Fibromyalgia	GERD
Gout	Heart Disease	Hepatitis
↑cholesterol	↑blood pressure	HIV
IBS	Kidney disease	Liver disease
MRSA	Osteoporosis	Spinal injury
Spinal stenosis	Stroke	Thyroid disease

OTHER:_____

Medications: please list or provide a printed/written list for us to record in your chart. ☐ check here if you take no medications

Medication Dosage

_____

_____

_____

_____

_____

We have the ability to communicate with your pharmacy to obtain and update your prescription information electronically. Do we have your permission to do so? ☐ YES ☐ NO

What is your preferred pharmacy? Name and phone number.

_____

Allergies: *If you have allergies, please grade the allergy as mild, moderate, or severe, and list your reaction:*

Allergen Mild/mod/severe Reaction

_____

_____

_____

_____

Social History: *Do you. . .*

-Smoke? N Y, for _____years, ____packs/day
Date quit:_____

-Use alcohol? N Y If yes, is it…..

Occasional (1-4 drinks/wk) Moderate (5-13 drinks/wk) Heavy (>14 drinks/wk)

-Use illegal drugs? N Y

If yes, what type?_____

-Exercise? N Y If yes, how many times/week?_____

What activities do you participate in?_____

_____

Surgical History: Please list any prior surgeries, including those to your foot or ankle:

_____

_____

_____

_____

_____

What is your chief complaint for your podiatrist today?

_____

_____

_____

_____

_____

_____

_____

What is your shoe size?_____

Have you ever been previously treated for this? Yes No

If yes, by whom? _____
Is this an injury that occurred at work? Yes No

Will this be a work comp claim? Yes No

If so, date of injury: _____

Did you miss work due to this injury/condition? Yes No

HIPAA Release: I certify that, in addition to providing the above information, I have been given the opportunity to review the HIPPA privacy acts, and understand that my Private Health Information will not be sold or shared without my permission.

Signature:_____ Date:_____

Consent to treatment, coordination of care, and billing of insurance: I agree, by signing below, that the information given is correct to the best of my knowledge and I consent to such diagnostic procedures (including x rays) and medical care/treatment as deemed necessary by Dr. Cindric. I also authorize Dr. Cindric to discuss my medical issues with other physicians of mine in the best interest in my overall patient care, if necessary. I also authorize release of information to SMB Medical Billing as necessary to file a claim with my insurance company, and assign all benefits payable to Dr. Cindric. I understand I am financially responsible for any balance not covered by my insurance carrier, including any deductible and copayments, as delineated in the practices' financial policy that has been provided to me.

Signature:_____ Date:_____

Thank you for taking the time to fill out this form completely. While much of the information may seem unnecessary or redundant, it will help us to serve you better today and in the future. If you have any questions or need assistance in filling it out, please ask at the front desk. Please return this to the front desk staff when complete, with your insurance card and photo ID. *Thank you!*