Welcome to our office

(**PLEASE PRINT** and **FILL OUT COMPLETELY**)

SSN_____ **Date**_____

(we need entire number for billing purposes)

Name_____**Spouse's Name**_____

Address_____**City**_____**Zip**_____

Phone

Home_____**Cell**_____**Buisness**_____

Age_____**Date of Birth**_____**Gender**_____**Marital Status: S M W D**

Email_____

Full time student: YES NO Parent/Guardian's name_____

Occupation_____**Employer**_____**Phone**_____

****Emergency Contact**_____**Phone**_____

****Primary Physician's NAME AND ADDRESS**_____

(IF YOU DO NOT HAVE ONE, PUT "NONE")

Former Podiatrist_____**Last seen**_____

****Describe your PRESENT FOOT/ANKLE PROBLEM**

_____

_____

Pain Level: 0(no pain) 1 2 3 4 5 6 7 8 9 10(most severe)

****How did you hear about us?**_____

Signature_____**Date**_____

Please provide Photo ID to the receptionist. This is for your protection and to abate fraud. 3/4

Medical History

Patient's Name_____**Date**_____

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

__I am NOT allergic to or have an adverse reaction to any substance to my knowledge
__I AM allergic to or have had an adverse reaction to (please check all that apply):
__Novocaine __Local Anesthesia __General Anesthesia __Penicillin **Other:**_____
__Naproxen __Aspirin __Vicodin __Demerol __Sulfa __Codeine __Iodine _____
__Shell Fish __Eggs __Adhesive/Tape __Percocet __Ibuprofen _____
Reaction?_____ _____

Do you have or have been treated for:
__Diabetes (how long?)_____Last A1c?_____Cancer (type?)_____ __Kidney Disease
__Stroke __Asthma __Anemia __Phlebitis __Bleeding Tendencies
__Lung Disease __Gout __Vascular Disease __Stomach Ulcers __Sciatica
__Liver Disease __Rheumatoid Arthritis __Lupus __Poor Circulation __Alzheimer's/Dementia
__Osteoarthritis __Thyroid Disease __Glaucoma __Heart Condition __High Blood Pressure
__Joint Implants __ICD/Pacemaker __AIDS __HIV Positive __Hepatitis A __Hepatitis B __Hepatitis C
__None of these **OTHER:**_____ _____
_____ _____

Past Surgeries_____
Please include all surgeries with approx. dates

_____

CURRENT MEDICATIONS and DOSAGE : _____ _____ _____

Please include prescription and over-the-counter medications. Please provide a list if you need additional room.

List the relationship of BIOLOGICAL FAMILY MEMBERS who have had:

Diabetes_____ Arthritis_____
Heart Disease_____Cancer_____(type?)_____

Are you currently pregnant? **__Yes __No**
Are you slow to healer after cuts? **__Yes __No**

Do you have abnormal (circle the ones that apply) **Bruising Bleeding Scarring**

Do you smoke? **__Yes __No** _____/_____/_____
Do you use any type of tobacco? **Type?** **__Yes __No** **Packs/day Years Smoked Quit date**
Do you drink alcohol? **__Yes __No** _____
Drinks per day?_____ **Type of Tobacco**
Do you use any illicit or recreational drugs? **Type?** **__Yes __No** _____
Type of illicit/recreational drug

Do you have (check all that apply):
__joint aches/pains __joint swelling __hip pain __low back pain __knee pain __ankle pain
__foot pain __limited motion in joints __morning stiffness __neck pain __abdominal pain __chest pain
__calf pain __thigh pain __nausea __vomitting __fever __chills __diarherra __headache/migraine
__shortness of breath __ear problems __nose problem __throat problems __dry skin __skin rash
__skin itching __skin cracking __thick or discolored toenails __thick or discolored fingernails
__tingling in feet/toes __pins and needles __skin cancer(type?)_____ __numbness
__shooting pain __radiating pain __INCREASED or DECREASED sensitivity to touch

SIGNATURE:_____ **DATE:**_____

Thank you. This extra effort on your part help us help you!

PODIATRY CENTER, INC.

Dennis J. Springer, DPM

Financial Policy

Thank you for choosing us to provide your podiatry care. We will always strive to provide you with the very best care.

We send billing out of house. In order for us to have accurate billing information, we ask that you bring your insurance card with you to every visit. We provide this service as a courtesy to you.

All copayments and applicable deductible payments are due at time of service. Copays are to be paid upon check-in. For your convenience we accept Cash, Check, Mastercard, Visa and Discover.

Balances left after your insurance pays are due upon receipt. If you are unable to pay the total balance in full, call our billing service (Drs. Central Billing, LLC) at **(513) 829-9333** to make payment arrangements.

At 90 days of past due balances, the account will be placed with a collection agency. We do not carry balances past 90 days.

Please let our receptionist know if you would like a copy of this form for your records.

Primary Insurance_____

Secondary Insurance_____

Party Responsible for account _____

Address_____Phone_____

By signing below, I fully understand and agree to the payment policy as explained above.
I authorize payment direct to PODIATRY CENTER, INC. (Dr. Springer).
I authorize the release of health information to my insurance company(s).
I authorize Podiatry Center, Inc. to act as my agent in helping me obtain payment form my insurance company(s).

Signature_____Date_____