PATIENT IDENTIFCATION AND CONTACT INFORMATION

First Name:	MI:	Last Name:	Occupation / Job Activity:

Last 4 of SSN:	Sex:	Age:	Birtnday:	Shoe Size:	Weight:	Height:
	M / F		/ /			

What name would you like to be addressed by: _____ Primary Care Doctor: _____

Please provide your preferred pharmacy: _____

COMPREHENSIVE MEDICAL HISTORY

Do you have or have you been treated for:

- o Stroke
- o Phlebitis
- o Anemia
- o Diabetes
- o Gout
- o Sciatica
- o Arthritis
- o Epilepsy
- o Asthma
- o Hepatitis
- o Dark Urine
- o Heart Attack
- o Vascular Disease
- o Poor Circulation
- o Kidney Disease
- o Osteoporosis
- o Lyme's Disease
- o Headaches
- o Nerve Disorder
- o Lung Disease
- o Liver Disease
- o Stomach Ulcer
- o High Blood Pressure
- o Heart Condition
- o Eye Problems
- o Alzheimer's
- o Psychiatric Disorder
- o Tuberculosis
- o Thyroid Problem
- o Other

_____
_____
_____

Please list any surgeries you have had:

_____
_____
_____
_____
_____
_____

List what medications you are currently taking:

_____
_____
_____
_____
_____
_____

Do you smoke now? ◯ Yes ◯ No
Did you ever smoke? ◯ Yes ◯ No
Alcoholic Beverages - ◯None ◯Rarely ◯Moderately
Recreational Drugs - ◯None ◯Rarely ◯Moderately

Allergies:

Latex, Adhesive Tape
Penicillin
Tylenol, Emprin
Aspirin, Advil, Aleve
Celebrex
Morphine
Shrimp, Iodine
Codeine
Demerol
Sulfa Drugs
Other _____
_____

Do your family members (parents, siblings or children) have any history of:

Diabetes- _____
Arthritis- _____
Stroke- _____
Cancer- _____
Foot Problem- _____
Heart Attack- _____
High Blood Pressure- _____

FOOT AND ANKLE HEALTH AND SURGERY
D. MATTHEW ALLEN, D.P.M.

PATIENT INFORMATION

Patient: (Last) _____ (First) _____ (M.I.) _____

E-Mail Address: _____

Mailing Address: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Employer/Company Name: _____

Employer Address: _____

Date of Birth: _____/_____/_____ SS#: _____ Marital Status: S____ M____ W____

GUARANTOR/RESPONSIBLE PARTY INFORMATION

Relationship to Patient: ◯ Spouse ◯ Parent ◯ Other

Name: _____ Date of Birth: _____/_____/_____ SS#: _____

Address: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Employer/Company Name: _____

Employer Address: _____

INSURANCE INFORMATION: *Will need a copy of insurance card(s)*

Primary _____ Secondary _____

FINANCIAL AGREEMENT

I understand that I am financially responsible for all charges and services pertaining to my care.

SIGNATURE: _____ DATE: _____

ASSIGNMENT OF BENEFITS AND RELEASE OF INFORMATION: I request that payment of authorized benefits be made, on my behalf, to Dr. Allen, for any services furnished to me by that provider. I authorize any holder of medical information to release to the HCFA and its agents any information needed to determine these benefits or the benefits payable for related services.

SIGNATURE: _____ DATE: _____

FOOT AND ANKLE HEALTH AND SURGERY
D. MATTHEW ALLEN, D.P.M.

CONSENT FOR TREATMENT

I hereby grant permission to D. Matthew Allen, D.P.M. to provide medical services as he deems necessary.

OUR FINANCIAL POLICY

Thank you for choosing us as your health care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered **as part of your treatment.** The following is a statement of **our financial policy** which we require that you read, agree to, and sign prior to any treatment.

1. Our office will file insurance claims for you, however, your share of the cost of our services is due at the time of service.

2. We accept cash, check, VISA, MasterCard or Discover.

3. We **do not** file third party insurance claims such as auto insurance, personal injury or accident insurance. It is your responsibility to pay for services rendered.

4. The adult bringing the minor for treatment is responsible for payment of services.

5. **CO-PAYS:** Your co-pay and deductible is due at the time of service. In order to be eligible participants with insurance companies, we must sign contracts agreeing to collect co-pays at the time service is rendered.

6. **INSURANCE CARDS:** If you do not bring in your insurance card and we are unable to verify your insurance, you will be required to pay for your visit in full.

7. **IF YOU ARE UNABLE TO TAKE CARE OF PAYMENT TODAY**, please ask to speak with the office manager so that we can authorize arrangements with your doctor.

8. **24 HOUR NOTICE**: Our office requires a 24 hour notice if you are unable to be at your scheduled appointment. If you fail to keep your appointment without notification a missed appointment fee of $25 will apply.

Thank you for understanding our financial policy. Please let us know if you have any questions or concerns.

I have read, understand, and agree to the above terms.

_____

SIGNATURE OF PATIENT OR LEGAL GUARDIAN DATE

FOOT AND ANKLE HEALTH AND SURGERY
D. MATTHEW ALLEN, D.P.M.

ACKNOWLEDGMENT OF REVIEW OF NOTICE OF PRIVACY PRACTICES

I have reviewed this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. (*Please let us know if you would like to review this information in detail)*

Furthermore, by my specific initials, I autnorize my physician and his staff, to contact me by the designated means noted below.

◯ Home Phone/Voicemail

◯ Office/Work Place/Voicemail

◯ Cell Phone/Voicemail

Additionally, by my initials I authorize my physician and his staff to communicate information regarding appointments, medical results and billing issues to:

◯ Spouse _____

◯ Others _____

This authorizatior shall remain in force until revoked in writing, Attention of Privacy Officer.

_____

Signature of Patient or Personal Representative

_____

Date