

WELCOME TO OUR OFFICE!

Dr. Kevin D. Smith

PATIENT INFORMATION

Name _____

Nickname _____ Sex: Male / Female

Birth Date _____ Age _____

Marital Status:

Single / Married / Divorced / Widowed

Social Security # _____

Address _____

City / State _____ Zip _____

Home Phone _____

Work Phone _____

Best Time / Place to call _____

Email _____

Occupation _____

Employer _____

Address _____

City / State _____ Zip _____

Employer Phone _____

How did you hear about our office?

Yellow Pages / Website / Family
Friend / Physician / Insurance Plan

Other: _____

We would like to thank them!

Name _____

Address _____

City / State _____ Zip _____

Date _____

INSURANCE

Insured Name _____

Relationship to Patient _____

Insured Birth Date _____

Is this patient covered by additional insurance?

YES

NO

MEDICATIONS

List all medications you are currently taking
including over-the-counter products, vitamins,
and herbals.

Pharmacy Name _____

ALLERGIES

Have you ever experienced any **ALLERGIES** or
ADVERSE EFFECTS to any of the following?

	YES	NO
Adhesives / Tape	<input type="checkbox"/>	<input type="checkbox"/>
Aspirin	<input type="checkbox"/>	<input type="checkbox"/>
Anti-Inflammatories	<input type="checkbox"/>	<input type="checkbox"/>
Codeine	<input type="checkbox"/>	<input type="checkbox"/>
Iodine (IVP dye)	<input type="checkbox"/>	<input type="checkbox"/>
Local Anesthetics (Novocaine / Lidocaine)	<input type="checkbox"/>	<input type="checkbox"/>
Penicillin	<input type="checkbox"/>	<input type="checkbox"/>
Sulfa Drugs	<input type="checkbox"/>	<input type="checkbox"/>

OTHER: _____

MEDICAL HISTORY

Please check "YES" or "NO" to indicate if you have had any of the following:

	YES	NO		YES	NO
AIDS / HIV	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	High Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>
Back Problems	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Problems	<input type="checkbox"/>	<input type="checkbox"/>
Blood Clots	<input type="checkbox"/>	<input type="checkbox"/>	Liver Problems	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Parkinson's Disease	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Psychiatric Problems	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	Stomach Ulcers	<input type="checkbox"/>	<input type="checkbox"/>
Eye Problems	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>
Foot / Leg Cramps	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Problems	<input type="checkbox"/>	<input type="checkbox"/>
Gout	<input type="checkbox"/>	<input type="checkbox"/>	Are you a smoker?	<input type="checkbox"/>	<input type="checkbox"/>

OTHER: _____

Please **list all surgeries** and approximate dates __________
_____**DIABETICS:** Please answer the following questions:

How many years have you been diagnosed as a diabetic? _____

Blood Sugar Checks: How many times each day? _____ Average reading? _____

FOOT HEALTH INFORMATION

What is your current foot problem? _____

When did it begin? _____

How have you treated this problem so far? _____

Have you seen another doctor for this problem? _____ If so, whom? _____

Have you ever seen a foot doctor? _____ If so, whom? _____

Shoe size _____ Height _____ Weight _____

Who is your **Primary Care Physician**? _____ Date of Last Visit _____

Physician's Address _____ Phone: _____

Are you under regular care for any specific problem? _____

In case of emergency, contact Name: _____ Phone: _____

ASSIGNMENT / RELEASE

- I, the undersigned, certify that I (or my dependent) have insurance coverage and assign directly to Dr. Kevin D Smith, DPM, PC all insurance benefits, if any, otherwise payable to me for services rendered.
- I understand I am financially responsible for all charges whether or not they are paid by insurance, and I may be billed if necessary for additional costs incurred in the collection of these accounts. I understand that it is ultimately my responsibility to know and understand my insurance plan.
- I understand it is my responsibility to submit claims to my secondary insurance for reimbursement.
- I also understand Dr. Smith's office does not accept Medicaid and I must notify the office if it my primary or secondary insurance. If I have Medicaid, I will be responsible for payment, for myself or my dependent, at the time of service.
- I hereby authorize Dr. Smith's office to release any private health information necessary in treatment, payment, or health care operations. I authorize the use of my signature on all insurance claim submissions. I understand I may revoke this release only in writing. I understand that this office does leave voicemail messages if we are unable to contact patients, unless instructed in writing not to do so.
- I certify that the information I have provided Dr. Smith's office is true and correct to the best of my knowledge. I give permission to Dr. Smith and staff to administer and perform such procedures as may be deemed necessary in my diagnosis and/or treatment.

PATIENT SIGNATURE (OR RESPONSIBLE PARTY)

DATE

WITNESS

DATE

PLEASE PRESENT YOUR INSURANCE CARD AND A PHOTO ID

A copy will become part of your medical record

MEDICARE PATIENT: MEDICARE ASSIGNMENT OF BENEFITS

I request that payment of Medicare, Medigap, or any other supplemental or secondary insurance benefits be made on my behalf to Dr. Kevin D Smith, DPM, PC for any services provided by this physician or group. I authorize the release of any private health information about me to the Centers for Medicare and Medicaid Services and its agents or to any other party necessary for treatment, payment, or health care operations.

PATIENT SIGNATURE (OR RESPONSIBLE PARTY)

DATE