

Date _____

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?

Family Friend Physician Insurance Plan

Other: _____

We would like to thank them!

Name _____

Address _____

City / State _____ Zip _____

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
- Aspirin
- Anti-Inflammatories
- Codeine
- Iodine (IVP dye)
- Local Anesthetics
(Novocaine / Lidocaine)
- Penicillin
- Sulfa Drugs

OTHER:

MEDICAL HISTORY

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

YES NO

YES NO

AIDS / HIV
Arthritis
Asthma
Back Problems
Blood Clots
Cancer
Diabetes
Epilepsy
Eye Problems
Foot / Leg Cramps
Gout

Hepatitis
High Blood Pressure
High Cholesterol
Kidney Problems
Liver Problems
Parkinson's Disease
Psychiatric Problems
Stomach Ulcers
Stroke
Thyroid Problems
Are you a smoker?

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: _____

Use this page for additional notes that do not fit in the lines from page 1 and page 2. Please reference the field name when writing notes on this page.

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 that I am financially responsible for all charges whether or not they are paid by my 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.
- Copays and payments for any products are due at the time of service
- Not all Podiatry services are a covered benefit with all insurance policies. In the event your health plan determines a service to be non-covered or you do not have a prior authorization or referral (if required by your plan) you will be responsible for all charges for services rendered.
- We will allow 60 days for your insurance company to pay any claims submitted to them. Any unpaid balance or claims are your responsibility.
- I also understand that Dr. Smith does not accept Illinois Medicaid and I must notify the office if it is 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 healthcare operations. I authorize the use of my signature on all insurance claim submissions. I understand that I may revoke this release only in writing. I understand that this office does leave voicemail messages and text messages if we are unable to contact patients, unless instructed in writing not to do so.
- I give permission to Dr. Smith and staff to administer and perform such procedures as may be deemed necessary in my diagnosis and treatment.
- I certify that the information I have provided is true and correct to the best of my knowledge.
- I acknowledge that I was offered a copy of the HIPAA Notice of Privacy Practices and that I have had the opportunity to read if I so chose and understand the notice. The HIPAA policy may be obtain from the front desk or at www.drsmithdpm.com

PATIENT SIGNATURE (OR RESPONSIBLE PARTY)

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