Page 3 is for any additional notes that do not fit in the fields on pages 1 and 2.

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			Hepatitis		
Arthritis			High Blood Pressure		
Asthma			High Cholesterol		
Back Problems			Kidney Problems		
Blood Clots			Liver Problems		
Cancer			Parkinson's Disease		
Diabetes			Psychiatric Problems		
Epilepsy			Stomach Ulcers		
Eye Problems			Stroke		
Foot / Leg Cramps			Thyroid Problems		
Gout			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 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.

- We will allow 60 days for your insurance company to pay any claims submitted to them. Any unpaid balance or unpaid claims are your responsibility.

- I also understand Dr. Smith does not accept Illinois 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 and Dr. Buckrop'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 is true and correct to the best of my knowledge. I give permission to Dr. Smith, Dr. Buckrop, 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

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 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