WELCOME TO OUR PRACTICE!

WESTERN OHIO PODIATRIC MEDICAL CENTER
M. Robert Maher, Matthew D. Painting, & Andrew Z. Schwartz
415 West Russ Rd
Greenville, OH 45331
Phone: (937) 548-1244

_____

PATIENT INFORMATION: *PLEASE PRINT*

Name _____
Last Name First Name MI

Street Address_____ **P.O. Box**_____ Home Phone (_____)_____

City_____ State_____ Zip_____ Cell (_____) _____

Sex: ☐ M ☐ F **Birthdate:** _____ SS# _____ **Marital Status**: ☐ Single ☐ Married ☐ Widowed

Preferred Appointment Reminder: ☐ Text ☐Call Email, if using our patient portal _____

Emergency contact: _____ Relationship_____ Phone (_____) _____

Ethnicity: ☐ Hispanic/Latino ☐ Not Hispanic/Latino

Race: ☐ American Indian or Alaska Native ☐ Asian ☐ Black/African American ☐ Native Hawaiian/Other Pacific Island ☐ White

Advanced Directives: ☐None ☐ Living Will ☐ Medical durable power of attorney ☐ other _____

Employment: Employer _____ Business Phone (_____)_____ ☐ Retired

Work Injury: Is this a work related Injury? ☐ Yes ☐ No Date of Injury: _____ Claim #:_____

RESPONSIBLE PARTY INFORMATION

Name (if different from the patient)_____ Phone_____

Complete Address_____

INSURANCE INFORMATION

(***MUST COMPLETE THIS SECTION, PLEASE***)

Primary Ins._____ Subscriber_____ DOB_____ Relationship _____

Secondary Ins._____ Subscriber_____ DOB_____ Relationship_____

ALLERGIES / SENSITIVITIES

Allergies or **Sensitivities to**: ☐ Sulfa ☐ Tape ☐ Latex ☐ Shellfish ☐ Iodine ☐Seasonal

☐ Medications_____ ☐ Food_____

☐ Anesthesia_____ ☐ None Known

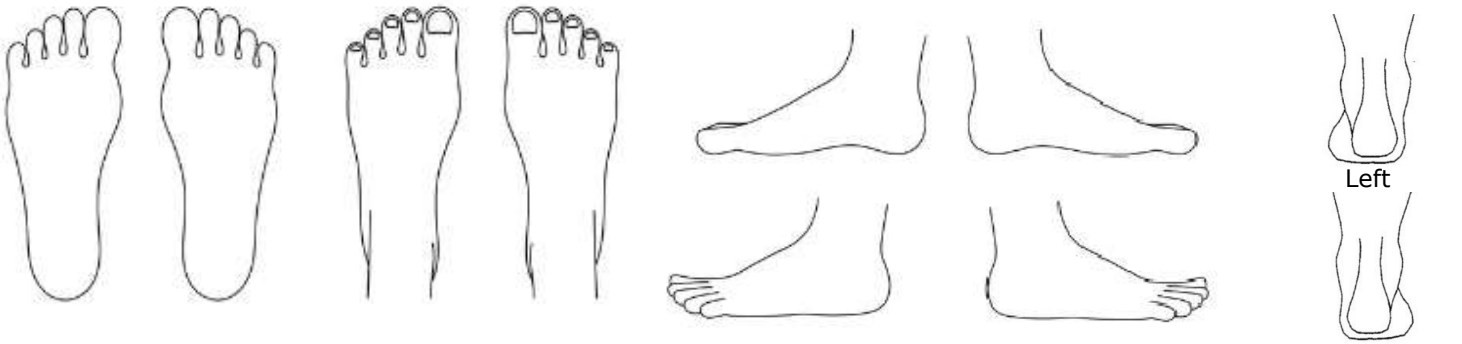
MEDICAL INFORMATION

Describe Your Foot/Ankle Problem: _____

How long have you had this problem? _____

Where is the pain/problem located? Please mark on the diagrams below:

Bottom of Foot | Top of Foot | Side of Foot | Back of Ankle



Left Right Left Right Left Right Left Right

How would you rate your pain on a scale from 0 to 10? (Please Circle)

(No Pain) 0 1 2 3 4 5 6 7 8 9 10 **(Worst Pain Possible)**

Have you had any past problems/surgical procedures performed on your feet and/or ankles? ☐ Yes ☐ No

If Yes, please list _____

Shoe Size _____ Current Weight _____ Height _____

Are you under a physician's care? ☐ Yes ☐ No If Yes, for what condition? _____

Name of **Family Physician** _____**Pharmacy**_____

May we contact your Family Physician about your health? ☐ Yes ☐ No

Check any of the following problems you have/had:

☐ Heart	☐ Circulation	☐ Stomach Ulcers	☐ High Blood Pressure
☐ Arthritis	☐ Tuberculosis	☐ Healing	☐ Low Blood Pressure
☐ Anemia	☐ Blood Clots	☐ Frequent Infections	☐ Ulcer/Open Sores
☐ Bladder	☐ Lung	☐ Intestines	☐ Neurological
☐ Neuropathy	☐ Cancer	☐ Kidneys	☐ Emotional/Psychiatric Disorder
☐ Skin	☐ Gout	☐ Stroke	
☐ Hormones	☐ Liver	☐ Bleeding Disorder	

Please **clarify** any above checked problems or unlisted problems or illnesses here: _____

_____

Do you have **Diabetes**? ☐ Yes (☐ Type 1 ☐ Type 2) ☐ No

If female, are you **pregnant**? ☐ Yes ☐ No

MEDICATIONS

Please list all **medications** you take on a regular basis. ***(If you have a list of your medications, our office staff will photocopy it.) By signing paperwork you give consent for our office to pull external medication history.***

_____

_____

_____

SURGICAL HISTORY

☐ Yes ☐ No Have you had any major surgeries? If Yes, please list _____

_____

☐ Yes ☐ No Do you have any **Artificial Joints**? If Yes, please list _____

☐ Yes ☐ No Do you have a **Heart Valve Implant**?

FAMILY HISTORY

Unknown, adopted: ☐ Yes ☐ No

Mother History of:

☐ Heart Disease ☐ Arthritis ☐ Bleeding Disorder ☐ Neurological Disorder
☐ Stroke ☐ Bunions ☐ Hammertoes ☐ Flatfeet
☐ Circulation problems of the legs/feet? ☐ Diabetes ☐ Other: _____

Father History of:

☐ Heart Disease ☐ Arthritis ☐ Bleeding Disorder ☐ Neurological Disorder
☐ Stroke ☐ Bunions ☐ Hammertoes ☐ Flatfeet
☐ Circulation problems of the legs/feet? ☐ Diabetes ☐ Other: _____

Sister(s) History of:

☐ Heart Disease ☐ Arthritis ☐ Bleeding Disorder ☐ Neurological Disorder
☐ Stroke ☐ Bunions ☐ Hammertoes ☐ Flatfeet
☐ Circulation problems of the legs/feet? ☐ Diabetes ☐ Other: _____

Brother (s) History of:

☐ Heart Disease ☐ Arthritis ☐ Bleeding Disorder ☐ Neurological Disorder
☐ Stroke ☐ Bunions ☐ Hammertoes ☐ Flatfeet
☐ Circulation problems of the legs/feet? ☐ Diabetes ☐ Other: _____

SOCIAL HISTORY

Alcohol Use: ☐ Never ☐ Current ☐ Past What Type? ☐ Beer ☐ Wine ☐ Liquor

Do you use tobacco products? ☐ Never ☐ Current ☐ Past If so, what type? _____

How many per day? _____ How long in use? _____ If applicable, how long ago did you quit? _____

Interest in Quitting: ☐ Yes ☐ No **Concerns about tobacco use in household:** ☐ Yes ☐ No

Do you use e-cigarettes? ☐ Never ☐ Yes ☐ No If so, how many per day? _____ How long in use?_____

Substance abuse? ☐ Never ☐ Current ☐ Past How Often? _____ If so, what type? _____

Signature _____ Date: _____

CONSENT TO TREAT, INSURANCE ASSIGNMENTS, FINANCIAL AGREEMENT, AUTHORIZATION TO RELEASE INFORMATION AND PRIVACY NOTICE ACKNOWLEDGEMENT

1. **CONSENT TO MEDICAL AND SURGICAL PROCEDURES** The undersigned consents to the medical and surgical care and treatment, as may be deemed necessary or advisable in the judgment of my physician or other provider, which may include but are not limited to laboratory procedures, x-ray examination, medical or surgical treatment or procedures, anesthesia, or other services rendered the patient under the general and special instructions of the patient's physician.

2. **ASSIGNMENT OF INSURANCE BENEFITS AND AUTHORIZATION TO RELEASE INFORMATION** In consideration of services rendered, I hereby transfer and assign to Western Ohio Podiatric Medical Center, Inc. (hereafter referred to as the practice) all rights, title and interest in any payment due to me for services described herein as provided in the above-mentioned policy or policies of insurance. The practice may disclose all or any part of the patient's record (including psychiatric, alcohol and drug abuse, family member or employer of the patient for all or part of the practice's charge, including but not limited to medical service companies, insurance companies, workers compensation carriers, welfare funds or the patient's employer. I further authorize physicians to access my medical prescription history via the Ohio Automated Rx Reporting System (OARRS), if deemed necessary, for my treatment.

3. **FINANCIAL AGREEMENT** The undersigned agrees, whether he/she signs as agent or as patient, that in consideration of the services to be rendered to the patient, he/she obligates himself/herself to pay the account of the practice in accordance with the regular rates and terms of the practice. Should the account be referred to an attorney for collections, the undersigned should pay reasonable attorney's fees and collection expense. The undersigned certifies that he/she has read the foregoing, receiving a copy thereof if requested, and is the patient or is duly authorized by the patient as patient's general agent to execute the above and accepts its terms.

4. **MEDICARE/MEDICAID** Patient's certification authorization to release information and payment request. I certify that the information given to me in applying for payment under Title XVIII/XIX of the Social Security Act is correct. I authorize that any holder of medical or other information about me may release to Social Security Administration/Division of Family Services or its intermediaries or carries any information needed for this or a related Medicare/Medicaid claim. I hereby certify all insurance pertaining to treatment shall be assigned to the practice treating me.

5. **USE OF COPIES** I permit a copy of these authorizations and assignments to be used in place of the original, which is on file at the practice.

6. **PAYMENT RESPONSIBILITY** I understand that certain insurance claims may be filed as a courtesy. However, if a claim is denied for any reason, I am responsible for payment. Insurance is considered a method of reimbursing the physician for services rendered to the patient. Some companies pay fixed allowances for certain procedures, and others pay a percentage of the charges. I understand it is my responsibility to pay any CO-PAY, DEDUCTIBLE, CO-INSURANCE, OR ANY OTHER BALANCE NOT PAID FOR BY MY INSURANCE OR THIRD PARTY PAYOR WITHIN A REASONABLE PERIOD OF TIME NOT TO EXCEED 60 DAYS.

NOTICE OF PRIVACY PRACTICE ACKNOWLEDGMENT

I have been given access to on this or a prior occasion the Summary of Notice of Privacy Practices and acknowledge that I have been given a copy, if requested. Received (Access to) Copy This Date: Yes ☐ No ☐ Previously: Yes ☐ No ☐

Patient /Legal Representative: _____ Witness:_____

Patient unable to acknowledge receipt of the Notice of Privacy ☐ Patient refused to Sign Acknowledgment ☐

Reason:

DATE: _____ PATIENT'S SIGNATURE_____

GUARANTOR/GUARDIAN SIGNATURE (if different than patient) _____

WESTERN OHIO PODIATRIC MEDICAL CENTER, INC.

RELEASE OF INFORMATION/AUTHORIZATION FORM

Name: _____ Date of Birth: _____/_____/_____

RELEASE OF INFORMATION

[ ] I authorize the release of information including the diagnosis, records, examination rendered to me and claims information. This information may be released to:

[ ] Name/Relationship _____

[ ] Name/Relationship _____

[ ] Name/Relationship_____

[ ] Information is not to be released to anyone.

This ***Release of Information*** will remain in effect until terminated by me in writing.

MESSAGES

Please call: [ ] my home [ ] my work [ ] my cell

Numbers: _____, _____, _____

If unable to reach me: [ ] you may leave a detailed message

[ ] please leave a message asking me to return your call

[ ] _____

MEDICAL RECORDS FAX TRANSMISSION AUTHORIZATION

I understand that you will be transmitting my medical records electronically and authorize you to do so, limited to physicians and insurance companies. If another party in error receives them, I absolve Western Ohio Podiatric Medical Center and its physicians of any and all liability relating to such submission of said records. (**Please check one**) **[ ] Yes [ ] No**

Signature:_____ **Date**: _____

Witness: _____ **Date**: _____

WESTERN OHIO PODIATRIC MEDICAL CENTER, INC.

Consent to Photograph

Name: _____ Date of Birth: _____/_____/_____

"I understand that photographs, videotapes, digital, or other images may be recorded to document my care, and I consent to this. I understand that Western Ohio Podiatric Medical Center, Inc will retain ownership rights to these photographs, videotapes, digital, or other images, but that I will be allowed access to view then or obtain copies. I understand that these images will be stored in a secure manner that will protect my privacy and that they will be kept for the time period required by law or outlined in Western Ohio Podiatric Medical Center's policy. Images that identify me will be released and/or used outside the institution only upon written authorization from me or my legal representative."

Signature:_____ **Date**: _____

Note: This consent does not authorize the use of images for the other purpose, such as teaching or publicity. A separate consent for photography for should be used for such purposes.