

# WESTERN OHIO PODIATRIC MEDICAL CENTER, INC.

415 W Russ Road, Greenville, Ohio 45331

Patient # \_\_\_\_\_

## 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 \_\_\_\_\_

## MEDICAL INFORMATION

Do you have Diabetes?  Yes (  Type 1  Type 2 )  No If female, are you pregnant?  Yes  No

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? \_\_\_\_\_

PLEASE TURN OVER PAGE

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

Medication Allergies \_\_\_\_\_  Food Allergies \_\_\_\_\_

Anesthesia Allergies \_\_\_\_\_  None Known

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.***

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**Family doctor:** \_\_\_\_\_ **Pharmacy:** \_\_\_\_\_

**Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

### **Consent to Photograph**

“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 them 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 purpose.*

**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:** \_\_\_\_\_