PATIENT INFORMATION

PATIENT'S FULL NAME (LAST / FIRST / M) | DATE

ADDRESS | CITY | STATE | ZIP

PHONE | BIRTHDATE | AGE | MARITAL STATUS S M D W | SEX

PATIENT'S OCCUPATION | EMPLOYER

PHONE | PATIENT'S SOCIAL SECURITY #

NAME OF PERSON RESPONSIBLE FOR BILLS

RELATION TO PATIENT | SOCIAL SECURITY #

EMPLOYER | PHONE

ADDRESS IF DIFFERENT THAN PATIENT'S

REFERRED TO OUR OFFICE BY

PATIENT'S PHYSICIAN | CITY

MEDICARE# | EFFECTIVE DATE

OTHER INSURANCE CO. | GROUP/ POLICY# | CATERPILLAR ID#

In case of an emergency, whom could we notify OTHER THAN SOMEONE LIVING IN YOUR HOUSEHOLD?

NAME _____ ADDRESS _____

PHONE _____ RELATIONSHIP TO PATIENT _____

We acknowledge the presence of and need for insurance by our patients; however, the contract is between you and your insurance company. Each patient, not the insurance company, is responsible for payment of all changes to his account at the time services are rendered. Yo assist you in obtaining reimbursement for covered expenses we provide you with an insurance coded receipt that is properly marked for your insurance company. With this coded receipt form it is not necessary for this office to fill out the insurance claim. Our customary fee will be charged for additional itemization of service.

PLEASE BE SPECIFIC IN ANSWERING THE FOLLOWING QUESTIONS

WHAT IS YOUR FOOT PROBLEM?

WHEN DID THIS PROBLEM START?

HAVE YOU HAD FOOT TREATMENT BEFORE? BY WHOM?

PLEASE LIST MEDICATIONS YOU ARE CURRENTLY TAKING.

PATIENT'S MEDICAL STATUS

YES	NO		YES	NO	
☐	☐	DIABETES	☐	☐	KIDNEY/LIVER PROB.
☐	☐	HIGH BLOOD PRESS.	☐	☐	STOMACH/BOWEL PROB
☐	☐	HEART DISEASE	☐	☐	ASTHMA
☐	☐	ARTHRITIS	☐	☐	BLOOD DISEASE
☐	☐	BURSITIS	☐	☐	CIRCULATION DISEASE
☐	☐	LEG CRAMPS	☐	☐	EPILEPSY
☐	☐	SMOKER	☐	☐	CANCER

ALLERGIES

YES	NO		YES	NO	
☐	☐	PENICILLIN	☐	☐	ADHESIVE TAPE
☐	☐	ASPIRIN	☐	☐	LOCAL ANESTHETIC
☐	☐	CODEINE	OTHER: _____		

I hereby request and authorize the physicians of ACPM Podiatry Group, Ltd. to administer treatment and to perform such general procedures as they may deem necessary in the diagnosis and/or treatment of my foot condition. This may include x-rays and/or photographs. I further certify that to the best of my belief and knowledge, the information provided is true and accurate.

PATIENT'S SIGNATURE _____ DATE _____

ACPM PODIATRY GROUP, LTD.

Dr. Curtis Ward
Dr. Anthony DeCeanne
Dr. Brent Parry

SIGNATURE ON FILE

☐ I authorize the doctor named above to use my name on any and all claims or documents that relate to health insurance benefits due to me and my dependents.

☐ I authorize release of any information related to any claims to all my Insurance Companies or other relevant parties.

☐ I understand that I am responsible for my bill and agree to pay all charges for services and items provided to me.

☐ I authorize my doctor to act as my agent in helping me obtain payment from my Insurance Companies.

☐ I authorize payment of health benefits otherwise payable to me, directly to my doctor.

☐ I permit a copy of this authorization to be used in place of the original.

☐ This "Signature on File" is valid for one year from the date indicated below.

Signature of Beneficiary, Guardian or Personal Representative	Medicare # (if applicable)	Date

Please print name of Beneficiary, Guardian or Personal Representative	Relationship to Beneficiary