

PATIENT INFORMATION

PATIENT'S FULL NAME	LAST	FIRST	M	DATE
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ADDRESS	CITY	STATE	ZIP
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PHONE	BIRTHDATE	AGE	MARITAL STATUS	S	M	D	W	SEX
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PATIENT'S OCCUPATION	EMPLOYER
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PHONE	PATIENT'S SOCIAL SECURITY #
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NAME OF PERSON RESPONSIBLE FOR BILLS _____

RELATION TO PATIENT	SOCIAL SECURITY #
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EMPLOYER	PHONE
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ADDRESS IF DIFFERENT THAN PATIENT'S _____

REFERRED TO OUR OFFICE BY _____

PATIENT'S PHYSICIAN	CITY
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MEDICARE#	EFFECTIVE DATE
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OTHER INSURANCE CO.	GROUP/ POLICY#	CATERPILLAR ID#
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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 charges to his account at the time services are rendered. To 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

<p>WHAT IS YOUR FOOT PROBLEM? _____</p> <p>WHEN DID THIS PROBLEM START? _____</p> <p>HAVE YOU HAD FOOT TREATMENT BEFORE? BY WHOM? _____</p> <p>PLEASE LIST MEDICATIONS YOU ARE CURRENTLY TAKING. _____</p>	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <th colspan="4" style="text-align: center;">PATIENT'S MEDICAL STATUS</th> </tr> <tr> <td style="width: 10%; text-align: center;">YES</td> <td style="width: 10%; text-align: center;">NO</td> <td style="width: 50%;"></td> <td style="width: 10%; text-align: center;">YES</td> <td style="width: 10%; text-align: center;">NO</td> <td style="width: 10%;"></td> </tr> <tr> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td>DIABETES</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td>KIDNEY/LIVER PROB.</td> </tr> <tr> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td>HIGH BLOOD PRESS.</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td>STOMACH/BOWEL PROB</td> </tr> <tr> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td>HEART DISEASE</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td>ASTHMA</td> </tr> <tr> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td>ARTHRITIS</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td>BLOOD DISEASE</td> </tr> <tr> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td>BURSITIS</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td>CIRCULATION DISEASE</td> </tr> <tr> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td>LEG CRAMPS</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td>EPILEPSY</td> </tr> <tr> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td>SMOKER</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td>CANCER</td> </tr> <tr> <th colspan="6" style="text-align: center;">ALLERGIES</th> </tr> <tr> <td style="text-align: center;">YES</td> <td style="text-align: center;">NO</td> <td style="width: 50%;"></td> <td style="text-align: center;">YES</td> <td style="text-align: center;">NO</td> <td style="width: 10%;"></td> </tr> <tr> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td>PENICILLIN</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td>ADHESIVE TAPE</td> </tr> <tr> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td>ASPIRIN</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td>LOCAL ANESTHETIC</td> </tr> <tr> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td>CODEINE</td> <td colspan="3">OTHER: _____</td> </tr> </table>	PATIENT'S MEDICAL STATUS				YES	NO		YES	NO		<input type="checkbox"/>	<input type="checkbox"/>	DIABETES	<input type="checkbox"/>	<input type="checkbox"/>	KIDNEY/LIVER PROB.	<input type="checkbox"/>	<input type="checkbox"/>	HIGH BLOOD PRESS.	<input type="checkbox"/>	<input type="checkbox"/>	STOMACH/BOWEL PROB	<input type="checkbox"/>	<input type="checkbox"/>	HEART DISEASE	<input type="checkbox"/>	<input type="checkbox"/>	ASTHMA	<input type="checkbox"/>	<input type="checkbox"/>	ARTHRITIS	<input type="checkbox"/>	<input type="checkbox"/>	BLOOD DISEASE	<input type="checkbox"/>	<input type="checkbox"/>	BURSITIS	<input type="checkbox"/>	<input type="checkbox"/>	CIRCULATION DISEASE	<input type="checkbox"/>	<input type="checkbox"/>	LEG CRAMPS	<input type="checkbox"/>	<input type="checkbox"/>	EPILEPSY	<input type="checkbox"/>	<input type="checkbox"/>	SMOKER	<input type="checkbox"/>	<input type="checkbox"/>	CANCER	ALLERGIES						YES	NO		YES	NO		<input type="checkbox"/>	<input type="checkbox"/>	PENICILLIN	<input type="checkbox"/>	<input type="checkbox"/>	ADHESIVE TAPE	<input type="checkbox"/>	<input type="checkbox"/>	ASPIRIN	<input type="checkbox"/>	<input type="checkbox"/>	LOCAL ANESTHETIC	<input type="checkbox"/>	<input type="checkbox"/>	CODEINE	OTHER: _____		
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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 # Date
(if applicable)

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