If you need help filling out this form, we will be happy to help. Just ask a member of our staff for assistance.

PODIATRIC ASSOCIATES OF NW OHIO, INC.

Date: _____

PATIENT HISTORY

PATIENT'S LAST NAME | FIRST NAME | MIDDLE | SOCIAL SECURITY #

ADDRESS | STREET | APT. NO. | CITY | STATE | ZIP

DATE OF BIRTH | AGE | SEX | MARITAL STATUS | HOME/CELL PHONE

EMAIL ADDRESS | EMPLOYER'S NAME | BUSINESS PHONE

INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY | ID # | GROUP # | POLICY HOLDER EMPLOYER

POLICY HOLDER NAME | S.S. # | D.O.B. | HOME PHONE | RELATION TO PATIENT

SECONDARY INSURANCE COMPANY | ID # | GROUP # | POLICY HOLDER EMPLOYER

POLICY HOLDER NAME | S.S. # | D.O.B. | HOME PHONE | RELATION TO PATIENT

HOW DID YOU FIND OUT ABOUT OUR OFFICE? _____

IF REFERRED, NAME OF PATIENT OR PHYSICIAN REFERRING: _____

IT IS OUR POLICY TO INFORM EACH PATIENT'S PRIMARY CARE PHYSICIAN CONCERNING THE TREATMENT GIVEN IN OUR OFFICE.

PRIMARY CARE PHYSICIAN _____ ADDRESS _____

I GIVE PERMISSION TO PODIATRIC ASSOCIATES OF NORTHWEST OHIO, INC. TO EXAMINE AND TREAT MY FEET AND ANKLES AND TO SUBMIT MY INCURRED CHARGES TO MY INSURANCE COMPANY.

SIGNATURE _____ DATE _____

AUTHORIZATION TO RELEASE PERSONAL HEALTH INFORMATION TO FAMILY AND FRIENDS

Name	Relationship	Home Phone	Cell Phone

I understand that I may revoke this authorization in writing at any time, except for the information that has already been disclosed by Podiatric Associates in reliance on this authorization, by sending a written revocation to: Podiatric Associates, 609 Ford Street, Maumee, Ohio, 43537

Patient Name

Name of Personal Representative (if applicable)

Signature of Patient | Date

Witness Signature | Date

(OVER)

If you need help filling out this form, we will be happy to help. Just ask a member of our staff for assistance.

PODIATRIC ASSOCIATES OF NW OHIO, INC.

Date: _____

MEDICAL INFORMATION

THIS INFORMATION IS IMPORTANT FOR OUR RECORDS AND YOUR HEALTH.

DESCRIBE YOUR FOOT/ANKLE PROBLEM: _____

_____

How long has it been bothering you? _____ Days _____ Weeks _____ Months _____ Years

What treatment have you tried? _____

Any past problems of your feet and ankles? _____

_____

Shoe Size _____ Current Weight _____ Current Height _____

CURRENT MEDICATIONS: (including supplements) _____

_____

Name of your pharmacy: _____ Phone # _____

ALLERGIES:

1. Antibiotics (penicillin, sulfa drugs, etc.) _____

2. Latex, Betadine (iodine), Metals (gold, etc.), Medical Tape, Other Medicines _____

_____

3. Any problem with local anesthetics (novocaine, lidocaine)? ☐ Yes ☐ No

4. Any problems taking aspirin or ibuprofen? (Advil, Motrin)? ☐ Yes ☐ No

LIST ANY SERIOUS ILLNESS WHICH YOU HAVE HAD: _____

_____

LIST ALL SURGERIES WHICH YOU HAVE HAD: _____

_____

PATIENT MEDICAL HISTORY:

1. Stroke ..... Yes ☐
2. Heart Attack ..... Yes ☐
3. Heart Disease ..... Yes ☐
4. High Blood Pressure ..... Yes ☐
5. Heart Murmur ..... Yes ☐
6. Cardiac Arrhythmia ..... Yes ☐
7. Cholesterol Disease ..... Yes ☐
8. Circulation Disease ..... Yes ☐
9. Diabetes ..... Yes ☐
10. Kidney Disease ..... Yes ☐
11. COPD/Emphysema ..... Yes ☐
12. Asthma ..... Yes ☐
13. Ulcer/GERD ..... Yes ☐
14. Bleeding Disorder ..... Yes ☐
15. Anemia ..... Yes ☐
16. Hepatitis (circle one) A B C ..... Yes ☐
17. HIV / AIDS ..... Yes ☐
18. Osteoporosis ..... Yes ☐
19. Fibromyalgia ..... Yes ☐
20. Arthritis ..... Yes ☐
    Type: _____
21. Gout ..... Yes ☐
22. Mental Illness ..... Yes ☐
23. Depression ..... Yes ☐
24. Thyroid Disease ..... Yes ☐
25. Pregnant ..... Yes ☐
26. Cancer ..... Yes ☐
    Type: _____
27. Frequent Infections ..... Yes ☐
28. Do you have any artificial joints? ... Yes ☐
    Type: Hip ☐ Knee ☐ Other _____
29. Do you smoke? ..... Yes ☐
    Packs per day _____
    How long been smoking? _____
30. Previously smoked? ..... Yes ☐
    Packs per day _____
    Date quite smoking _____
31. Recreation drugs? ..... Yes ☐
32. Drink alcohol or beer? ..... Yes ☐
    light (1-2 per week) ☐ moderate (1-2 per day) ☐
    heavy (more than 2 daily) ☐
33. EMPLOYMENT (check all that apply):
    Sit at job ☐ Stands and walks at job ☐ Retired ☐
    Stand at job ☐ Other ☐
34. EXERCISE ROUTINE ..... Yes ☐
    Type: _____ Frequency: _____

PODIATRIC ASSOCIATES OF NW OHIO, INC.

Patient Financial Policy

Your understanding of our financial policies is an essential element of your care and treatment. If you have any questions, please discuss them with our front office staff or supervisor.

- As our patient, you are responsible **for all authorizations/referrals** needed to seek treatment in this office.

- Unless other arrangements have been made in advance by you, or your health insurance carrier, payment for office services are due at the time of service. We will accept VISA, MasterCard, Discover, cash or check. **Failure to pay your co-pay at the time of service will result in a $5.00 charge.**

- Your insurance policy is a contract between you and your insurance company. As a courtesy, we will file your insurance claim for you if you assign the benefits to the doctor. In other words, you agree to have your insurance company pay the doctor directly. If your insurance company does not pay the practice within a reasonable period, we will have to look to you for payment.

- We have made prior arrangements with certain insurers and other health plans to accept an assignment of benefits. We will bill those plans with which we have an agreement and will only require you to pay the co-pay/co-insurance/ deductible at the time of service.

- If you have insurance coverage with a plan with which we do not have a prior agreement, we will prepare and send the claim for you on an unassigned basis. This means your insurer will send the payment directly to you. Therefore, all charges for your care and treatment are due at the time of service.

- All health plans are not the same and do not cover the same services. In the event your health plan determines a service to be "not covered," or you do not have an authorization, you will be responsible for the complete charge. Patients are encouraged to contact their plans for clarification of benefits prior to services rendered.

- You must inform the office of all-insurance changes and authorization/referral requirements. In the event the office is not informed, you will be responsible for any charges denied.
- For most services provided in the hospital, we will bill your health plan. Any balance due is your responsibility.

- There are certain elective surgical procedures for which we require pre-payment. You will be informed in advance if your procedure is one of those. In that event, payment will be due one week prior to the surgery.

- **Past due accounts are subject to collection proceedings.** All costs incurred including, but not limited to, collection fees, attorney fees and court fees shall be your responsibility in addition to the balance due this office.

- **There is a service fee of $30.00 for all returned checks.** Your insurance company does not cover this fee.

- **CHARGES FOR MISSED APPOINTMENTS**: Office visit $25.00 - Surgery/Procedure $50.00 (this is not covered by insurance)

Completion of Forms - There is a $20.00 fee for each form completion such as FMLA, Disability, etc. This is due from the patient prior to the form being completed.

Copy of Medical Records or X-ray - A fee of $10.00 will be charged for a copy of the x-ray. The fee for medical records follows the Ohio law.

Printed Name of Patient/Responsible Party: _____

Signature of Patient/Responsible Party: _____ **Date:** _____

_____ Patient initials to indicate copy received

Revised May 2022