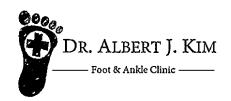


### Patient Information Form

Patient Information				
Patient Name: ( Mr.   Mrs.   Ms	.):			
		Firs	E	Middle
Address:		City	State	Zip Code
Date of Birth:		-		·
Home Phone: ()		_ Work or Cell Ph	one: ()	
Employer Name:		Address:		
In Case of Emergency, Co	ntact:			
Name:	Relationship:	Pho	ne: <u>( )</u>	
Primary Care Physician (to	o whom reports ma	y be sent)		
Name:	Phone:			
Address:				
Referred by:				
Doctor Name:	🗆 Frie	end or FamilyName		
□ Web Search □ GroupOn □ Yelp	☐ Near home/wo	ork 🗆 Insurance 🛭	Other reason	
Preferred Pharmacy:				
Pharmacy Name:		Pharmac	y Phone: <u>(</u> )	<del></del>
Pharmacy Address:				······
Insurance Information	Primary Insu	rance	Secondary In	surance
nsurance Company		<del></del> <u>-</u>		
I hereby consent to and authorize the considered necessary in the judgme necessary to communicate with referenced benefits to the attending plant paid by insurance. I authorize the	nt of the attending perring physicians and physician(s). I underst	ohysician(s). I authori I to process insuranc and that I am financia	ze the release of me e claims. I authorize ally responsible for a	dical information direct payment of
 Date	Signature of Resp	oonsible Party	Rei	ationship, if not Patient



## Patient Medical History Form

Patient Name:					
Please indicate if you now have or have had problems with any of these by marking an "X".  Ankle pain Athlete's foot Bunions Corns and calluses Cramps in feet or legs Flat feet Heel pain Ingrown toenails Injuries to the foot Plantar warts Swelling in ankles or feet Tired feet	Athletic activities in which you participate (please list and indicate frequency):  List surgeries, serious injuries, and serious illnesses:				
Medications you are taking (prescription, non-prescription, herbal supplements, vitamins, etc.):					
	Please indicate if you now have or have had problems with any of these by marking an "X".  Ankle pain Athlete's foot Bunions Corns and calluses Cramps in feet or legs Flat feet Heel pain Ingrown toenails Injuries to the foot Plantar warts Swelling in ankles or feet Tired feet  Medications you are taking (prescription, non-prescription,				

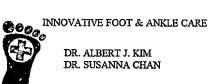


# Patient Medical History Form

## **General Medical History**

Your occupation Your height Your weight	Please indicate if you or a family member now have or have had any of the following by marking an "X".	Please indicate if you or a family member now have or have had any of the following by marking an "X".	
Do you smoke?  Yes No  Have you ever smoked?  Yes No How much?  Pears smoked  Drink alcoho!?  Yes No How much?  Recreational drugs?  Yes No What?  Pregnant or possibly pregnant?  Yes No	You Member  Anemia Arthritis Artificial heart valves Artificial joints Asthma Back problems Bleed easily Cancer Chemical dependency Chest pain Circulatory problems Diabetes Deep vein thromboses Epilepsy Fibromyalgia Gout Heart disease	You Member  Heartburn, chronic Hemophilia Hepatitis High blood pressure HiV/AIDS Kidney problems Liver disease Lung/respiratory disease Mental illness Phlebitis Psoriasis Rheumatic fever Stroke Thyroid problem Tuberculosis Ulcers, stomach Varicose veins Venereal disease	
	correct to the best of my knowledge. nd perform such procedures as may b		
Date	Signature of Responsible Party	Relationship, if not Patient	
	Printed Name of Responsible Party	<del></del>	

Date: \_\_\_\_



DIC 50	Authorization, Assignment and Release
N	
initials	AUTHORIZATION TO RELEASE INFORMATION: You are authorized to release any information you deem appropriate concerning my physical condition to any insurance company, attorney or adjuster, or doctor in order to process any claim for reimbursement of charges incurred by me as a result of professional services rendered by you and I hereby release you of any consequence thereof.
Initials	ASSIGNMENT OF PAYMENT: My insurance company is hereby requested to pay direct to Innovative Foot & Ankle Care listed below, any monies due on account, the same to be deducted from any settlement made on my behalf. Further, I agree to pay the difference if any, between the total amount of his charges and the amount paid him by the attorney and/or insurance company. It is further understood that I, the undersigned, agree to pay the full amount of charges, should my condition be such that it is not covered by my policy or if for any reason the insurance company and/or attorney refuses to pay my claim.
Initials	POSITIVE VERIFICATION OF COVERAGE CANNOT BE OBTAINED: 1 understand that any insurance verification made on our behalf is only a rough estimate and <u>NOT</u> an exact verification. It is the patient's responsibility to obtain true and accurate insurance verification and exact payment required for services.
initials	RESPONSIBILITY TO PAY: I understand that I am personally responsible to pay all charges that are not covered by my insurance, including but not limited to, co-pays, deductibles, and non-covered services such as custom orthotics or any other materials dispensed in the office.
	<b>该最级的现在分词的现在分词的一个人们的一个人们的人们的人们的人们的人们的人们的人们的人们的人们的人们的人们的人们的人们的人</b>
	Medicare Only
	MEDICARE ASSIGNMENT: I authorize any holder of medical or other information about me to release the Social Security Administration and Health Care Financing Administration of its' intermediaries or carriers any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits.
	<sup>大小</sup> 中间,一个一个一个一个一个一个一个一个一个一个一个一个一个一个一个一个一个一个一个
	I hereby acknowledge that I am receiving (or about to receive) health care services at Innovative Foot & Ankle Care and that I have been advised that the doctor providing the services is willing to wait for payment for these services, provided that there continues to be a reasonable chance that payment will be made by the insurance proceeds.
	I further understand that I am responsible for any collection and/or legal fees incurred in the collection of any past due charges.
	I understand that if it is determined that there is no insurance company obligated to pay for the services, or if the insurance company involved refuses to acknowledge an assignment to the doctor then payment of services rendered by the doctor at Innovative Foot & Ankle Care will be made promptly and my bill to be paid in full.
	I hereby irrevocably assign all medical payments to Innovative Foot & Ankle Care for my medical care from my insurance carriers.
	I have read and understand the above. I understand my possible financial responsibility. I hereby authorize Innovative Foot & Ankle Care to release all information necessary to secure the payment of benefits. 1 hereby affix my signature as an acknowledgement of this understanding. 1 authorize a photocopy of this release and assignment as valid.
	Patient's Signature (Parent's Signature if minor)  Witness