DR. DONALD E. CHUDY

PODIATRIC MEDICINE AND FOOT SURGERY

DIPLOMATE AMERICAN BOARD OF PODIATRIC SURGERY

WELCOME TO OUR OFFICE TODAY'S DATE

PLEASE COMPLETE IN FULL

PATIENTS NAME:			DOB:	AGE:
SS NO:	HEIGHT:	WEIGHT:	SHOE SIZE:	MALE ☐ FEMALE ☐
LOCAL ADDRESS:	CITY & STATE:		ZIP CODE:	PHONE:
OTHER ADDRESS:	CITY & STATE:		ZIP CODE:	PHONE:
PATIENTS EMPLOYER:		OCCUPATION:		CELL PHONE:
EMPLOYER ADDRESS:	CITY & STATE:		ZIP CODE:	PHONE:
SPOUSE'S NAME		NAME OF PARENT OR GUARDIAN IF UNDER 18:		

MEDICAL INFORMATION

FAMILY DOCTOR: PHONE NO:

DRUG ALLERGIES:

☐ NONE ☐ CODEINE
☐ PENICILLIN ☐ SULFA
☐ IODINE ☐ TAPE
☐ LOCAL ANESTHESIA (LIDOCAINE)
☐ OTHER

CURRENT MEDICATIONS:

PAST FOOT PROBLEMS OR SURGERY:

REASON FOR TODAY'S VISIT: (LOCATION, DURATION, PRIOR TREATMENT, ETC.)

PATIENT MEDICAL HISTORY

☐ NONE
☐ DIABETES
☐ HIGH BLOOD PRESSURE
☐ HEART DISEASE
☐ STROKE
☐ GOUT
☐ KIDNEY DISEASE
☐ HEPATITIS
☐ BLEEDING PROBLEMS
☐ STOMACH ULCER
☐ LIVER DISEASE
☐ PREGNANT
☐ SMOKING
☐ CANCER
☐ IMPLANTS (JOINTS, VALVES, ETC.)
☐ ARTHRITIS
☐ AIDS/HIV
☐ OTHER

INSURANCE INFORMATION

PRIMARY INSURANCE: ☐ NONE ☐ MEDICARE ☐ OTHER _____

SECONDARY INSURANCE: ☐ NONE ☐ MEDICARE ☐ OTHER _____

POLICY HOLDER NAME: _____ DOB: _____ SS NO: _____

RELATIONSHIP TO PATIENT: _____ EMPLOYER: _____ PHONE: _____

WHO MAY WE THANK FOR REFERRING YOU TO OUR OFFICE:

☐ YELLOW PAGES ☐ DOCTOR ☐ FRIEND OR RELATIVE ☐ OTHER NAME _____

WE REQUEST THAT YOUR OFFICE VISIT BE PAID FOR AT THE TIME SERVICE IS RENDERED, UNLESS OTHER PAYMENT ARRANGEMENTS HAVE BEEN MADE.

SIGNATURE _____ DATE _____

PATIENT OR RESPONSIBLE ADULT

DONALD E. CHUDY, DPM
PODIATRIC MEDICINE AND FOOT SURGERY

INSURANCE AUTHORIZATION

I AUTHORIZE AND REQUEST THAT PAYMENT UNDER MY INSURANCE PROGRAM(S) BE MADE DIRECTLY TO DONALD E. CHUDY, DPM FOR SERVICES PROVIDED. I ALSO AUTHORIZE THE RELEASE OF NECESSARY INFORMATION REQUIRED FOR PROCESSING OF CLAIM PAYMENT. I PERMIT COPIES OF THIS AUTHORIZATION TO BE USED IN PLACE OF ORIGINAL. IN ADDITION I AGREE TO BE FINANCIALLY RESPONSIBLE FOR ALL SERVICES PROVIDED INCLUDING APPLICABLE CO-INSURANCE, CO-PAYMENTS AND NON-COVERED SERVICES PROVIDED UNDER DR. CHUDY'S CARE. PATIENT IS RESPONSIBLE TO PROVIDE COMPLETE ACCURATE INFORMATION REQUIRED TO RENDER INSURANCE PAYMENT.

SIGNATURE OF INSURED/PARENT **DATE**

****MEDICARE PATIENTS****

DR. CHUDY IS A PARTICIPATING PROVIDER WITH MEDICARE. WE WILL BILL MEDICARE AND MOST SECONDARY INSURANCES AS A COURTESY. MEDICARE PATIENTS ARE RESPONSIBLE FOR THEIR MEDICARE DEDUCTIBLE, CO-INSURANCE (20%) AND ANY NON-COVERED SERVICES PROVIDED. ****MEDICARE DOES NOT COVER WHAT THEY DEEM ROUTINE FOOT CARE WHICH IS DEFINED AS THE TRIMMING OF NAILS, CORNS AND CALLUSES WHICH IS CONSIDERED A NON-COVERED SERVICE****

SIGNATURE OF MEDICARE BENEFICIARY **DATE**