Hilliard Family PODIATRY, LLC.

PATIENT FULL NAME: DATE OF BIRTH: GENDER: ☐ FEMALE ☐ MALE

SOC SEC # MARITAL STATUS: ☐ MARRIED ☐ SINGLE ☐ PARTNERED ☐ DIVORCED ☐ WIDOWED

RACE (MAY CHECK MORE THAN ONE): ☐ WHITE ☐ PACIFIC ISLANDER ETHNICITY: LANGUAGE:
☐ AMERICAN INDIAN ☐ ASIAN ☐ BLACK/AFRICAN AMERICAN ☐ HISPANIC ☐ NON-HISPANIC

ADDRESS: CITY: STATE: ZIP:

PRIMARY PHONE: **TYPE: H/W/C** SECONDARY PHONE: **TYPE: H/W/C** OKAY TO **LEAVE MESSAGE:** ☐ **YES** ☐ **NO**
OKAY TO **TEXT:** ☐ **YES** ☐ **NO**

E-MAIL ADDRESS:

EMPLOYER: PHONE: OCCUPATION:

RESPONSIBLE PARTY: ☐ **SELF** ☐ **SPOUSE** ☐ **PARENT** ☐ **OTHER** _____
ADDRESS: CITY: STATE: ZIP:

DOB: SOC SEC #: PRIMARY PHONE #:

EMERGENCY CONTACT: RELATIONSHIP: PHONE #:

INSURANCE INFORMATION

Primary Insurance:

ID#: GROUP #:

SUBSCRIBER: SOC SEC #: DOB:

Secondary Insurance:

ID#: GROUP #:

SUBSCRIBER: SOC SEC #: DOB:

PRIMARY CARE/ PHARMACY / REFERAL

PRIMARY CARE PHYSICIAN: PHONE: DATE LAST SEEN:

PHARMACY: PHONE: ZIP:

REFERAL:

☐ DR._____ ☐ PATIENT ☐ INTERNET ☐ INSURANCE ☐ ADVERTISMENT ☐ OTHER:_____

I hereby give permission for Hilliard Family Podiatry to render the proposed podiatric examination and treatment. I authorize the release of any information to my insurance company and any medical information necessary to process any claim and I request payment of insurance benefit due to Hilliard Family Podiatry to be paid directly to Hilliard Family Podiatry. I hereby give my permission for Hilliard Family Podiatry to forward any pertinent medical information to my primary of referring physicians for continuity of care.

I permit a copy of this authorization to be used in place of the original. This authorization may be revoked at any time by either me or my insurance company in writing.

The above information is true and I will notify Hilliard Family Podiatry of any changed.

Signature: _____ Date: _____

Hilliard Family PODIATRY, LLC.

SOCIAL HISTORY

DO YOU SMOKE? ☐ NO ☐ PAST USE ☐ YES HOW MANY PACKS PER DAY? ____ FOR HOW LONG? ____
DO YOU USE DRUGS? ☐ NO ☐ YES ☐ PAST USER
DO YOU DRINK ALCOHOL? ☐ NO ☐ YES (☐ 1-2 DRINKS/MONTH ☐ 1-2 DRINKS/WEEK ☐ 2-3 DRINKS/WEEK ☐ 3+ DRINKS/WEEK)
EXERCISE? ☐ NEVER ☐ OCCASIONALLY ☐ WEEKLY ☐ DAILY

HEIGHT	**WEIGHT**	**SHOE SIZE**

MEDICAL HISTORY

AIDS/HIV	☐ SELF	☐ FAMILY	HIGH CHOLESTEROL	☐ SELF	☐ FAMILY
ANEMIA	☐ SELF	☐ FAMILY	HYPERTENSION	☐ SELF	☐ FAMILY
ANXIETY	☐ SELF	☐ FAMILY	KIDNEY PROBLEMS / DISEASE	☐ SELF	☐ FAMILY
ARTHRITIS (GENERAL)	☐ SELF	☐ FAMILY	MENTAL DISORDER	☐ SELF	☐ FAMILY
ASTHMA	☐ SELF	☐ FAMILY	OPEN SORES	☐ SELF	☐ FAMILY
BACK PAIN	☐ SELF	☐ FAMILY	OSTEOPOROSIS	☐ SELF	☐ FAMILY
BLEEDING DISORDER	☐ SELF	☐ FAMILY	POOR CIRCULATION	☐ SELF	☐ FAMILY
BLOOD CLOTS	☐ SELF	☐ FAMILY	RHEUMATOID ARTHRITIS	☐ SELF	☐ FAMILY
CANCER	☐ SELF	☐ FAMILY	SLEEP APNEA	☐ SELF	☐ FAMILY
DEPRESSION	☐ SELF	☐ FAMILY	STD / STI	☐ SELF	☐ FAMILY
EPILEPSY / SEIZURES	☐ SELF	☐ FAMILY	STOMACH ULCERS	☐ SELF	☐ FAMILY
FIBROMYALGIA	☐ SELF	☐ FAMILY	STROKE	☐ SELF	☐ FAMILY
GOUT	☐ SELF	☐ FAMILY	THYROID / HIGH / LOW	☐ SELF	☐ FAMILY
HEADACHES	☐ SELF	☐ FAMILY	TUBERCULOSIS ACTIVE / NON	☐ SELF	☐ FAMILY
HEARING PROBLEMS	☐ SELF	☐ FAMILY	VEIN DISORDER	☐ SELF	☐ FAMILY
HEART DISEASE	☐ SELF	☐ FAMILY	VISION PROBLEMS	☐ SELF	☐ FAMILY
HEPATITIS (A / B / C)	☐ SELF	☐ FAMILY			
PLEASE LIST OTHERS:					
HAVE YOU HAD ANY OF THE FOLLOWING:	CHICKEN POX		MEASLES	MUMPS	POLIO

DO YOU HAVE DIABETES: ☐ YES ☐ NO HOW LONG?
HOW DO YOU CONTROL YOUR DIABETES? ☐ DIET ☐ INSULIN ☐ OTHER MEDICATION
WHAT WAS YOUR LAST BLOOD SUGAR LEVEL OR A1C?

ALLERGIES ☐ NO KNOWN ALLERGIES

NAME	REACTION	NAME	REACTION	NAME	REACTION
___ASPIRIN		___NSAIDS		___PENICILLIN	
___CODEINE		___DEMEROL		___ANESTHETICS	
___CORTISONE		___SULFA		___LATEX	
___IODINE/ SHELLFISH		___TAPE/ ADHESIVES		___IV CONTRAST (DYE)	
LIST ANY OTHERS:					
ENVIRONMENTAL / FOOD:					

MEDICATION LIST

NAME OF MEDICATION	REASON FOR MEDICATION

Hilliard Family PODIATRY, LLC.

HISTORY OF ANY GENERAL SURGERIES:	DATE/YEAR:

HISTORY OF ANY FOOT SURGERIES:	DATE/YEAR:

PAST DIAGNOSTIC TESTING

(MRI / X-RAY / CT)	DATE	WHERE WAS THE TEST PERFORMED

REASON FOR VISIT:

_____

_____

LENGTH OF CONDITION: _____ DAYS / WEEKS / MONTHS / YEARS

LOCATION: _____

CHARACTERISTICS OF PAIN: ACHING NUMB BURNING DULL SHOOTING SHARP STABBING ITCHING DEEP SUPERFICIAL

PAIN LEVEL: **0 1 2 3 4 5 6 7 8 9 10**

PAST TREATMENTS:

_____

_____

_____

PREVIOUS DOCTORS SEEN FOR THIS CONDITION:

WHAT HAS HELPED SYMPTOMS:

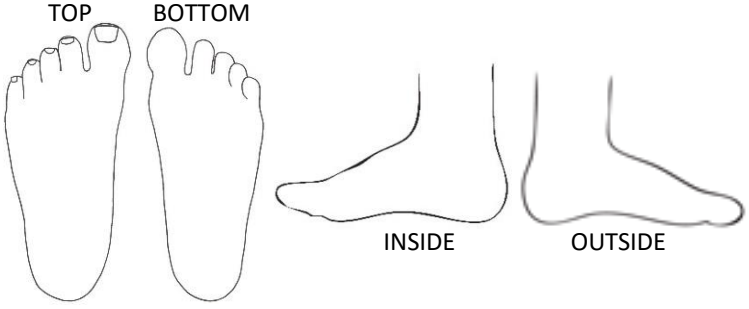
_____

WHAT MAKES SYMPTOMS WORSE:

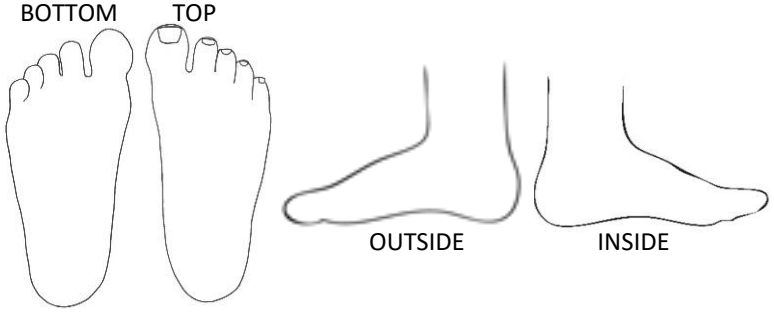
_____

CIRCLE PROBLEMATIC AREAS

LEFT FOOT



RIGHT FOOT



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PATIENT FINANCIAL RESPONSIBILITY FOR NO INSURNACE: If no insurance is to be filed by us, full payment is expected at the time of service.

CO-PAYMENTS: Are due at the time of service. We accept cash, checks and credit cards.

MINORS/DEPENDENTS: Only a parent, custodial parent in a divorce situation or guardian are able to authorize treatment. The parent, custodial parent or guardian is responsible for the full fee for services. A copy of the custodial or guardianship agreement is requested for our records if applicable.

METHOD OF PAYMENT: Acceptable methods of payment are cash, check, VISA, MasterCard and Discover Debit/credit card payments can also be accepted by phone.

NSF FEES: A fee of at least $25 but no less than the amount charged by the bank will be added to the patient's account per submission in cases of returned checks for non-sufficient funds (NSF).

PAST DUE ACCOUNTS: Outstanding balances after insurance payment will be invoiced to the responsible party on a statement. Payment is due upon receipt of the statement. Prolonged delinquency in payment may result in preparation of account for small claims court, collection agency and/or credit bureau reporting with possible discharge from the practice. In the event an account is turned over for collection the person financially responsible for the account will be responsible for all collection costs including interest, collection fees, and reasonable attorney fees and court costs.

MISSED APPOINTMENTS: We request the courtesy of a 24-hour notice of cancellation. After missed appointments, $20 maybe charged your account. We also reserve the right not to schedule you with our office any further, or you may be discharged from the practice entirely.

MISSED/ CANCELLED SURGERIES: We request a 48-hour notice to cancel all scheduled surgeries no matter the location of the surgery. If a 48-hours notice is not given a $50 charge may be applied to your account.

I AUTHORIZE COMMUNICATION WITH THE FOLLOWING PEOPLE LISTED BELOW REGARDING MY HEALTHCARE:

NAME	PHONE	RELATIONSHIP

FINANCIAL AGREEMENT: By signing this form, I, the patient, or the patient's representative, acknowledges that I have read, understood and received a copy of the Ohio Foot and Ankle Center Financial Policy. I understand and agree, regardless of my insurance status, that I am responsible for the balance of my account.

PATIENT'S PRINTED NAME	DATE

PATIENT OR RESPONSIBLE PARTY SIGNATURE	DATE