Williamsburg Podiatry

PATIENT INFORMATION

Patient Name _____ Birthdate _____
Last First MI MM/DD/YYYY

Gender (circle one)
M or F Marital Status _____ Race _____ Social Security _____

Language _____ Address _____ City _____

State _____ Zip Code _____ Employer Name _____ Employer Phone _____

Occupation _____ How did you hear about us? _____ Primary Care Physician _____

Default pharmacy / Address Former Podiatrist _____

_____ Refering Provider / Phone # _____

CONTACT INFORMATION

Home Phone ( ) _____ Cell Phone ( ) _____ Concent to text message Yes or No
Circle One
Contact Preference: Home or Cell Phone Email address _____

If you are unavailable, may we leave detailed confidential information on your voicemail? Yes or No
In addition to our appoinment reminder calls, would you like to recieve appointment reminder via email? Yes or No
If any of the following call or answer the phone, detailed confidential information about my health may be shared with them:

Next of Kin

Name _____ Relationship to Patient _____ Phone ( ) _____

Emergency Contact

Name _____ Relationship to Patient _____ Phone ( ) _____

INSURANCE

Primary Company _____ Policy Holder _____

Member ID / Policy ID # _____ Group # _____

Secundary Company _____ Policy Holder _____

Member ID / Policy ID # _____ Group # _____

Name of Person Responsible for Bill _____
Last First MI

Gender (circle one) Male or Female Date of Birth _____ SSN _____

Adress _____ City _____

State _____ Zip Code _____ Phone ( ) _____ Relationship to Patient _____
If patient is 18 years or less. Please fill the Guardian information

_____
Last First MI

SOCIAL HISTORY

Do you smoke? _____ Yes or No If yes, how much? _____

Do you drink? _____ Yes or No If yes, how much? _____

Have you ever smoked? Yes or No For how long? _____ When did you quit? _____

Do you exercise Yes or No If yes, how often? _____ How Long? _____

What form of exercises? _____

MEDICAL HISTORY

State in your own words the reason(s) for coming to our office _____

Please list all medicines that you currently use or attach list. Please include over the counter _____

Woman Only: Are you pregnant? Yes or No if yes, how many months? _____ Are you trying to become pregnant? Yes or No

Please indicate by checking Yes or No if you've had significant problems wth the following:

Abnormal bleeding (Yes / No)	Gout (Yes / No)	Hepatitis (Yes / No)	Swelling feet/ankles (Yes / No)
Anemia (Yes / No)	Headaches (Yes / No)	Mental/Emotional problems (Yes / No)	Tyroid (Yes / No)
Arthritis (Yes / No)	Heart (Yes / No)	Recent weight loss (Yes / No)	Vision problems (Yes / No)
Asthma (Yes / No)	Hearing Problems (Yes / No)	Seizures (Yes / No)	Other:
Circulation (Yes / No)	Kidney Stone/disease (Yes / No)	Shortness of breath (Yes / No)	Other:
Cramp/Numbness (Yes / No)	Low back pain/injury (Yes / No)	Skin problems/cancer (Yes / No)	Other:
Diabetes (Yes / No)	Lung (Yes / No)	Stomach problems (Yes / No)	Other:
Fainting/Convulsion (Yes / No)	liver/Gallbladder (Yes / No)	Stroke (Yes / No)	Other:

List any Allergies _____

Operations / Serious Injuries _____

Family History:

Family Member	Cancer	Diabetes	High Blood Preasure	Stroke	Gout

Any additional information or comments you would like to provide:

PLEASE READ AND SIGN BELOW:

I hereby authorize treatment and authorize the provider of medical services to release information for those services to my insurance carrier for payment. I further authorize that payment of benefits be made directly to Michael A. Dente, DPM on my behalf. I understand that I am ultimately responsible for any amount not covered by my insurance carrier and I agree to pay all fees and charges for such treatment. **ALL COPAYMENTS and DEDUCTIBLES ARE DUE AT THE TIME OF SERVICE.** Should I present for an appointment without securing necessary authorization/referrals, as required by my insurance carrier, I agree to accept responsibility for charges in full. I understand that the patient is ultimately responsible for his/her own policy with the insurance carrier(s), including knowledge of elegibility and benefits, as well as physician participation status with the insurance carrier. should I choose to be treated by a non-participating physician or facility, I elect to be held responsible for all charges accrued. I understand that a charge may be assessed for missed appointments. **$35.00 for missed appointments within 24 hours on $50.00 for no show and $65.00 for office surgery on procedure within 72 hours.** Charges shown by statement are agreed to be correct unless protested within 30 days of billing date in writing. It is agreed that all payments will be made in a timely fashion and will not be delayed or withheld due to pending insurance. Should my account become delinquent; (90 days without response), I agree to assume reponsibility for any collection / attorney fees not to exceed one-third of the unpaid balance and court costs incurred. This agreement will remain in effect until changed by my written notice.

Signature: _____ **Date:** _____