Williamsburg Podiatry

Patient Information

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

Gender M or F **Marital Status** _____ **Race** _____ **Language** _____ **Social Security #**_____

Address_____

Home Phone #_____**Cell #**_____**Contact Preference**: Home or Cell Phone **Consent to text**: Yes or No

If you are unavailable, may we leave detailed confidential information on your voicemail? Yes or No

In addition to our appointment reminder calls, would you like to receive appointment reminder via email? Yes or No

Email Address _____

If any of the following call or answer the phone, detailed confidential information about my health may be shared with them:

Emergency Contact _____**Relationship to Patient** _____ **Phone #** _____

Preferred Pharmacy/Address_____ **Primary Care Physician**_____

Employer Name _____ **Work #**_____ **Occupation**_____

How did you hear about us?_____ **Former Podiatrist** _____

Insurance Information

Name of Person Responsible for Bill _____ **Relationship to Patient** _____

Primary Company _____ **Policy Holder** _____

Member ID # _____ **Group #** _____

Secondary Company _____ **Policy Holder** _____

Member ID # _____ **Group #** _____

Social History

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

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

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

Do you exercise? Yes or No If yes, how often and for how long? _____

What form of exercises? _____

Medical History

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

Anemia Yes / No	Abnormal Bleeding Yes / No	Seizures Yes / No
Arthritis Yes / No	Circulation Yes / No	Shortness of Breath Yes / No
Asthma Yes / No	Cramp/Numbness Yes / No	Skin Problems/Cancer Yes / No
Diabetes Yes / No	Fainting/Convulsion Yes / No	Stomach Problems Yes / No
Gout Yes / No	Hearing Problems Yes / No	Stroke Yes / No
Headaches Yes / No	Hepatitis Yes / No	Swelling Feet/Ankles Yes / No
Heart/Blood Pressure Issues Yes / No	Low Back Pain/Injury Yes / No	Thyroid Yes / No
Kidney Disease Yes / No	Mental/Emotional Problems Yes / No	Vision Problems Yes / No
Liver Disease Yes / No	Recent Weight Loss Yes / No	Pacemaker Yes / No

Please list all medicines that you are currently taking (include over the counter) _____

_____

List any allergies _____

Operations / Serious Injuries _____

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

_____

_____

Family History:

Family Member	Cancer	Diabetes	High Blood Pressure	Stroke	Gout

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 eligibility and benefits, as well as physician participation status with the insurance carrier. should I choose to be treated by a nonparticipating 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 cancellations within 24 hours, $50.00 for no show, and $65.00 for cancellation within 72 hours for an office procedure**. 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 responsibility 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 _____