FAMILY FOOT CARE MD

Dr. Jeffrey Idol Dr. Ruth Devadas Dr. Mary Clare Zavada

Podiatric Medicine and Surgery

Patient Registration/Information Form

Please Print

Patient's Name:_____Date:_____
First Middle Last
Date of Birth:_____ Age_____

Gender:___Male___Female Marital Status: __Single __Married __Widowed __Divorced

Home Address:_____

City:_____State:_____Zip Code:_____

Billing Address: (if different than above)_____

E mail Address:_____

Home Phone: _____Cell Phone:_____

Primary Care Physician:_____Phone:_____

Name of your Pharmacy:_____

Employer's Name:_____Employer's Phone:_____

Occupation:_____

Emergency Contact:_____Phone:_____Relationship:_____
Name of Custodial Parent/Guardian of Minor/Mentally Challenged Adult_____

Primary Insurance Company:_____
Policy Holder's Name:_____DOB:_____
Policy Holder's Employer Name:_____Employer's #_____

Secondary Insurance Company:_____
Policy Holder's Name:_____DOB:_____
Policy Holder's Employer's Name_____Employer's #_____

I declare that all the above information is complete and accurate.

_____ _____
Signature Date

FAMILY FOOT CARE MD

Dr. Jeffrey Idol **Dr. Ruth Devadas** **Dr. Mary Clare Zavada**

Podiatric Medicine and Surgery

Patient History

NAME:_____ DOB:_____VISIT DATE:_____

REASON FOR TODAYS VISIT_____

IS YOUR CONDITION WORK-ACCIDENT RELATED?_____
PRIMARY PHYSICIAN:_____REFERRING PHYSICIAN:_____

PERSONAL MEDICAL HISTORY	(CHECK YES OR NO)		
Angina (Chest Pain)	YES____NO____	High Blood Pressure	YES____NO____
Artificial Joints	YES____NO____	HIV/AIDS	YES____NO____
Asthma/COPD	YES____NO____	Kidney Disease	YES____NO____
Autoimmune Disease	YES____NO____	Liver Disease/Hepatitis	YES____NO____
Bleeding Disorder	YES____NO____	Osteoarthritis	YES____NO____
Cancer	YES____NO____	Pacemaker	YES____NO____
Congestive Heart Failure	YES____NO____	Poor Circulation	YES____NO____
Diabetes Type I	YES____NO____	Rheumatoid Arthritis	YES____NO____
Diabetes Type II	YES____NO____	Rheumatic Fever	YES____NO____
Emphysema	YES____NO____	Seizures	YES____NO____
Gastric Reflux	YES____NO____	Stomach Ulcers	YES____NO____
Gout	YES____NO____	Stroke	YES____NO____
Heart Attack	YES____NO____	Thyroid Disease	YES____NO____
Heart Disease	YES____NO____	Tuberculosis	YES____NO____

Other Disease(s) not listed:_____
MEDICATIONS:_____
ALLERGIES:_____
LIST ALL PAST SURGERIES:_____
HAVE YOU EVER HAD A REACTION TO ANESTHESIA? YES_____NO_____
IF YES, EXPLAIN:_____
DO YOU SMOKE? YES_____NO_____ IF YES, HOW MUCH PER DAY?_____
DO YOU USE CHEWING TOBACCO? YES_____ NO_____
DO YOU DRINK ALCOHOL? YES__NO__IF YES, WHAT AND HOW MUCH?_____
ARE YOU PREGNANT? YES ___NO___ IF YES, DATE OF EXPECTANCY_____
FAMILY HISTORY (CHECK YES OR NO)
DIABETES YES ____NO____ RELATIONSHIP_____
CANCER YES____NO____ RELATIONSHIP_____
HEART DISEASE YES____NO____ RELATIONSHIP_____

I declare that all of the above information is complete and accurate.

_____ _____

Signature **Date**

FAMILY FOOT CARE MD

Dr. Jeffrey Idol Dr. Ruth Devadas Dr. Mary Clare Zavada

ASSIGNMENT AND RELEASE

I, The undersigned, certify that I (or my Dependent) have Insurance coverage with

_____

I directly assign to Family Foot Care all insurance benefits, if any, otherwise payable for services rendered. I hereby authorize the Doctor to release all information necessary to secure the payment of benefits. I authorize the use of this Signature on all insurance submissions.

SIGNATURE:_____ **DATE**:_____

If my insurance requires a referral or authorization number prior to consultation with Family Foot Care MD, I accept responsibility for charges for services rendered if I do not provide this requirement.

NON COVERED BENEFITS

If procedures and pre-existing conditions are not covered by my insurance, I assume full financial responsibility for all services rendered by Family Foot Care, MD..

Note: Deductible and Co-Insurance amounts will be collected prior to office visit and prior to surgeries.

COLLECTIONS

I understand that Full Payment on outstanding balances is due within 30 days. A late fee of $20.00 per month will be added to any missed monthly payments. An interest charge of 18% will accrue per year. This fee will incur on all outstanding balances past 30 days. I also understand that delinquent accounts will be sent to a collection agency and/or attorney, at which time I will be responsible for all court costs, filing fees, interest charges, attorney's fees, and collection fees. Payments may be made by cash, check, debit, or credit cards. When using credit cards, there is a 3% service fee added.

XRAY

Xrays are part of your permanent record and must remain in our office. You may, however, obtain copies of your films with prior notice. The fee for this service is $5.00 per copy and must be paid prior to receiving your copies.

MEDICAL RECORDS

A copy of your medical notes will be available to you, if requested. You may have special forms that need to be completed by your physician for disability benefits and other types of coverage. Please allow 3-5working days for completion. There is a $25.00 fee for the completion of these forms.

ORTHOTICS

In the event that you require orthotics for your shoe gear, or other medical braces and/or appliances, you will be expected to pay any balance that is not covered by your insurance company.

CONSENT

I, _____hereby give my consent for Family Foot Care MD to consult and provide medical/or surgical treatment for my mentally disabled and or minor daughter/son or custodian.

CANCELLATION OF APPOINTMENT

A 24 hour notice is required for all cancelled appointments. All messages are dated and timed. I understand that failure to comply with this requirement will result in a charge assessed to me. This Charge must be paid prior to the next scheduled appointment.

_____(Initials) I have read the notice of privacy practices. I am aware that a copy of this document will be given to me at my request.

I have read and agree to comply with the above policies.

Signature:_____Date:_____