

Alvin Family Foot Specialists

Thank you for choosing our office! Please take a few minutes to fill out this form as completely as you can. Please print clearly. If you have questions we'll be glad to help you. We look forward to working with you in maintaining your health.

Last Name: _____ First Name: _____ MI: _____
Street: _____ Apt. # _____ City/State: _____ Zip: _____
Phone: _____ Social Security # _____ - _____ - _____ Sex: (M or F): _____ Age: _____
Birth date: _____ Marital Status: S M W D Mobile/Cell #: _____ Occupation: _____
Employer/(School, if Student): _____ Wk Phone: _____ ext. _____
Employer Address: _____ City/State: _____ Zip: _____
Spouse or Parent's Name: _____ Soc. Sec. # _____ - _____ - _____ Birth date: _____
Spouse or Parent's Employer: _____ Phone # _____
Patient's Family Doctor _____ Date Last Seen: _____ Telephone # _____
Whom May We Thank For Referring You? _____

How did you hear about our office? (circle) *insurance-book; telephone-book; friend; other:* _____

In Case of Emergency Contact (not living in same household):

Name: _____ Relationship: _____ Phone #: _____ Wk #: _____

***** RESPONSIBLE PARTY *****

Name of Person Responsible for this account: _____ Relationship to Patient: _____

Address: _____ City/State: _____ Zip: _____ Phone: _____

Employer of Responsible Party _____ Wk #: _____ Soc. Sec. #: _____

***** INSURANCE INFORMATION *****

Insured's Name: _____ Insured's Birth date: _____ Employer: _____

Insurance Company: _____ Policy #: _____ Group #: _____ Ins. Phone # _____

Do You Have A Secondary Insurance? YES or NO (circle) if yes; complete the following:

Insured's Name: _____ Insured's Birth date: _____ Relation to patient: _____

Insurance Company: _____ Address: _____

Policy #: _____ Group #: _____ Ins. Phone # _____

***** AUTHORIZATION AND CONSENT FOR HEALTH CARE*****

I hereby authorize Douglas E. Webb, DPM & Associates, P.A. or other providers to release any information acquired in the course of my treatment to my insurance company, employer, or third party payer as required for claims filed, quality assurance, health plan administration, or complaints/grievances. I understand that the specific information to be released may include, but is not limited to history, diagnosis and/or treatment of all related illnesses including HIV virus and Acquired Immune Deficiency Syndrome (AIDS). I authorize direct payment to be made to Douglas E. Webb, DPM & Associates, P.A. or other providers for any and all medical or surgical services/supplies rendered. I understand that if any services or charges are not covered, or if Douglas E. Webb, DPM & Associates, P.A. is unable to verify eligibility, I am responsible for all charges incurred for services rendered.

Signature of Responsible Party: _____

Relationship to Patient: _____

Date _____

Medical History

Patient Name: _____ Age: _____
 My foot problem is: _____ How Long? _____
 Prior or self-treatment for this problem: _____ How Long? _____
 Employment: Sit at job Stand at job Stand & walk at job Retired
 Does employer require any particular type of shoes? Boots Heels Other
 Height: _____ Weight: _____ Shoe Size: _____ If female, could you be pregnant? Yes No
 Name of Family Doctor: _____ Date Last Seen: _____ Phone: _____

Circle/List any condition(s) in your Past medical history or that you Currently have:

Alcoholism	Diabetes	Hepatitis	Liver Problems	Pacemaker
Anemia	Insulin? Yes No	Heart Problem	Multiple Sclerosis	Rheumatic Fever
Asthma	Epilepsy	High Blood Pressure	Phlebitis	Shortness of Breath
Arthritis	"Bleeder"	HIV (AIDS)	Poor Circulation	Stomach Ulcer
Blood Disorder	Fainting Spells	Kidney Problems	Pneumonia	Stroke
Cancer	Gout	Leg Cramps	Prone to Infection	Tuberculosis

 Other illnesses or medical problems _____

Circle yes or no and complete the following information:
 Do you drink alcohol? Yes No If yes, amount _____ Artificial joints: Yes No
 Do you smoke? Yes No If yes, amount _____ Knee Yes No
 Do you take any illegal drugs? Yes No If yes, amount _____ Heart Valve implant? Yes No
 Do you take any medications? Yes No (include prescriptions, over the counter medications, vitamins & herbals)
 If yes, list name & dosage: _____

Name & Location of your Pharmacy: _____ Phone () - _____

Additional system review; Circle/list any condition(s) You currently have:

Allergies (seasonal)	Eye Disorder	Muscle/Joint Pain	Sores in Mouth
Anxiety	Fast/Slow pulse	Nasal/Sinus problem	Stomach problem
Bleeder	Fever	Nerve Pain	Swallowing difficulty
Blood in Urine	Gland problem	Nervous disorder	Thyroid disorder
Breast Lumps	Hormone problem	Neurological problem	Ulcers/Skin change
Chest Pain	Lymph gland disorder	Poor Vision	Urine/Kidney problem
Dizziness	Mental/Emotional problem	Skin problem	Weight Gain/Loss
Ear/Hearing difficulty	Migraine Headache	Sore throat	Other: _____

Circle &/or list any Allergic reactions you have experienced from the following:

Penicillin	Aspirin	Cortisone	Morphine	Sulfa	Adhesive tape	Latex
Codeine	Antibiotics	Demerol	Iodine/Betadine	Novacaine or other Anesthetics		Seafood

 Other: _____

Do you have any problems taking aspirin or ibuprofen (Advil, Motrin)?
 Circle Yes or No to report your Family History (blood relatives): _____ Relative

Diabetes	Yes	No	<u>Relative</u>	Tuberculosis:	Yes	No
Cancer	Yes	No		High Blood Pressure:	Yes	No
Hepatitis	Yes	No		HIV (AIDS):	Yes	No
Bunions	Yes	No		Heart Problems/Stroke:	Yes	No
Hammertoes	Yes	No		Circulation Problem Leg/Ft:	Yes	No

Please list any Surgeries and/or Hospitalizations you have had:
 _____ Date: _____
 _____ Date: _____
 _____ Date: _____
 _____ Date: _____

Consent

I certify that the above information is true and correct to the best of my knowledge. I hereby voluntarily consent to such healthcare encompassing diagnostic procedures and treatment by my physician, and my physician's associates, assistants, and other healthcare providers, as may be necessary in my physician's judgment. I will immediately notify Dr. Douglas E. Webb in writing, any changes in my medical information.

Patient's Signature: _____ Date: _____
 Parent or Legal Guardian's Signature: _____ Date: _____

DOUGLAS E. WEBB JR. DPM, & ASSOCIATES,P.A.

RECEIPT OF NOTICE OF PRIVACY
PRACTICES WRITTEN
ACKNOWLEDGEMENT FORM

I, _____, have received a copy of

Print Patient Name

DOUGLAS E. WEBB JR. DPM, & ASSOCIATES, P.A.'s Notice of Privacy Practices

and I have been provided an opportunity to review it.

Signature of Patient

Date

Patient Financial Policy

We are dedicated to providing the best possible care and service to you and regard your complete understanding of our financial policies as an essential element of your care and treatment. If you have any questions, please discuss them with our front office staff or supervisor.

As our patient, you are responsible for all authorizations/referrals needed to seek treatment in this office.

Unless other arrangements have been made in advance by you, or your health insurance carrier, payment for office services are due at the time of service. We will accept VISA, MasterCard, American Express, Discover, cash or check.

Your insurance policy is a contract between you and your insurance company. As a courtesy, we will file your insurance claim for you if you assign the benefits to the doctor. In other words, you agree to have your insurance company pay the doctor directly. If your insurance company does not pay the practice within a reasonable period, we will have to look to you for payment.

We have made prior arrangements with insurers and other health plans to accept an assignment of benefits. We will bill those plans with which we have an agreement and will only require you to pay the co-pay/co-insurance/deductible at the time of service

If you have insurance coverage with a plan with which we do not have a prior agreement, we will prepare and send the claim for you on an unassigned basis. This means your insurer will send the payment directly to you. Therefore, all charges for your care and treatment are due at the time of service.

All health plans are not the same and do not cover the same services. In the event your health plan determines a service to be "not covered," or you do not have an authorization, you will be responsible for the complete charge. We will attempt to verify benefits for some specialized services; however, you remain responsible for charges to any service rendered. Patients are encouraged to contact their plans for clarification of benefits prior to services rendered.

You must inform the office of all- insurance changes and authorization referral requirements. In the event the office is not informed, in a timely manner, you will be responsible for any charges denied.

For most services provided in the hospital, we will bill your health plan. Any balance due IS your responsibility.

There are certain elective surgical procedures that we require pre-payment. You will be informed in advance if your procedure is one of those. In that event, payment will be due .one week prior to the surgery.

Past due accounts are subject to collection proceedings. All fees including, but not limited to collection fees, attorney fees and court fees shall become your responsibility in addition to the balance due this office.

There is a service fee of\$25.00 for all returned checks. Your insurance company does not cover this fee.

Signature of Patient/Responsible Party:

Printed Name: _____

Date: _____

Witness: _____

Date: _____