FAMILY FOOT CARE OF SOUTHERN MARYLAND

Dr. Jeffrey Idol **Dr. Judith Olkaba** **Dr. Ruth Devadas**
Podiatric Medicine and Surgery

Patient Registration/Information Form

Please Print

Patient's Name:_____ **Date:**_____
First Middle Last

Date of Birth:_____ **Age**_____ **Social Security Number:**_____

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:**_____

Employer's Name:_____ **Employer's Phone:**_____

Occupation:_____

Primary Contact:_____ **Phone:**_____ **Relationship:**_____

Name of Custodial Parent/Guardian of Minor/Mentally Challenged Adult_____

Primary Insurance Company:_____
Policy Holder's Name:_____ **DOB:**_____ **SS#**_____
Policy Holder's Employer Name:_____ **Employer's #**_____

Secondary Insurance Company:_____
Policy Holder's Name:_____ **DOB:**_____ **SS#**_____
Policy Holder's Employer's Name_____ **Employer's #**_____

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

_____ _____
Signature **Date**

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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___	Rheumatoid Arthritis	YES___NO___
Diabetes Type I	YES___NO___	Rheumatic Fever	YES___NO___
Diabetes Type II	YES___NO___	Seizures	YES___NO___
Emphysema	YES___NO___	Stomach Ulcers	YES___NO___
Gastric Reflux	YES___NO___	Stroke	YES___NO___
Gout	YES___NO___	Thyroid Disease	YES___NO___
Heart Attack	YES___NO___	Tuberculosis	YES___NO___
Heart Disease	YES___NO___		

Other Disease(s) not listed:_____
MEDICATIONS:_____
NAME OF YOUR PHARMACY:_____
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**

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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 of Southern Maryland, 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 of Southern Maryland.

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 cost, 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 3-5 working 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 of Southern Maryland 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 $30.00 charge assessted 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:**_____