BARBERTON FOOT AND ANKLE

PODIATRIC REGISTRATION AND HISTORY FORM

OFFICE USE ONLY
PATIENT ACCT #
WC ☐ TC ☐
SC ☐ PF ☐

OFFICE USE ONLY
EXP ☐ NP ☐ RF ☐
HC ☐

DATE: ___________

************* PATIENT INFORMATION *************

Patient Name: ____
LAST NAME *FIRST NAME* *MIDDLE INITIAL*

Home Address: ____
STREET ADDRESS *SUITE OR APT #*

____
CITY *STATE* *ZIP CODE*

☐ *Male* ☐ *Female* *Birthdate:* ____________ *Age:* ________
MM/DD/YYYY

Social Security #: ______________________________ ☐ *Single* ☐ *Married* ☐ *Widow* ☐ *Other* ________

Home Phone: ________________________________ *Cell Phone:* ____

Preferred method of contacting you: ☐ *Home* ☐ *Cell*

Your Emergency Contact: _________________________________ *Phone Number:* ____________________________

Your Emergency Contact Relationship to You: ☐ *Spouse* ☐ *Sibling* ☐ *Friend* ☐ *Mother* ☐ *Father* ☐ *Other*

Email Address: ____

Employer: ____ *Occupation:* _______________________________

How did you hear about us? ____

********** ***INSURANCE*** **********

Name of Person Insured, listed on the card: ____

Birthdate: ______________________________ ***Social Security #:*** ___________________________

What is the Relationship to the Person Insured: ☐ ***Self*** ☐ ***Spouse*** ☐ ***Child*** ☐ ***Other*** ____________

Primary Insurance Company: ____
Member ID: ______________________________________***Group ID:***__________________________

Secondary Insurance Company: ____
Member ID: ______________________________________***Group ID:*** __________________________

Third Insurance Company: ____
Member ID: ______________________________________***Group ID:***__________________________

Release of Benefits Information: *I authorize my insurance benefits to be paid directly to* ***Dr. James Zimmermann****. I understand that* ***Dr. James Zimmermann's*** *office will bill my insurance as a courtesy and that I am responsible at the time of service for all co-payments, deductibles and non-covered services. I authorize the release of information required to process any claims.*

All co-payments and deductibles are due on the day of services

Patient Signature: _______________________________________ ***Date:*** ______________

********** ***PODIATRIC HISTORY*** **********

What is the chief complaint for which you came to Dr. Zimmermann's office to be treated? ________________

____

Have you ever been to a Podiatrist before? ☐ ***Yes*** ☐ ***No*** ***If yes, please list:*** ***Name:*** ________________

Last Visit: ________________

Is there any personal or family history of Diabetes? ☐ ***Yes*** ☐ ***No***

Shoe Size: ___________

Cigarette/Tobacco Use: ☐ ***Yes*** ☐ ***No*** ***If yes, please list years smoked:*** _________

********** PODIATRIC HISTORY (CONTINUED) **********

Please indicate your past and present medical history: (please check below ✓)

___ AIDS/HIV
___ Anemia
___ Angina
___ Ankle Pain
___ Arthritis
___ Artificial Heart Valves or Joints
___ Asthma
___ Back Problems
___ Bleeding Disorders
___ Bunions
___ Cancer

___ Chemical Dependency
___ Chest Pain
___ Circulatory Problems
___ Corns & Callouses
___ ***Diabetes***
___ Ear Problems
___ Epilepsy
___ Eye Problems
___ Fainting
___ Flat Feet
___ Foot or Leg Cramps
___ Gout

___ Headaches
___ Heart Disease
___ Heel Pain
___ Hemophilia
___ Hepatitis
___ High Blood Pressure
___ Ingrown Toenails
___ Kidney Problems
___ Liver Disease
___ Low Blood Pressure
___ Nervous Problems
___ Phlebitis

___ Plantar's Warts
___ Psychiatric Care
___ Radiation Treatment
___ Rash
___ Respiratory Disease
___ Rheumatic Fever
___ Shortness of Breath
___ Sinus Problems
___ Stroke
___ Swelling in Ankles, Feet
___ Tired Feet
___ Tuberculosis

___ Ulcers
___ Varicose Veins
___ Venereal Disease
___ Weight Loss
____ ***Other*** ___________

Surgeries you have had: ____
____
____

Family Physician: ____ ***Last Date Seen:*** ___________________

********** CONSENT FOR TREATMENT **********

I certify that the information that I have disclosed, is true and correct to the best of my knowledge. I give my permission to ***Dr. James Zimmermann*** *to administer and perform such procedures as may be deemed necessary in the diagnosis and/or treatment of my feet and ankles.*

____ ________________________

Patient's Signature, POA or Guardian ***Date***

PATIENT MEDICATION/ALLERGY FORM

Patient Name: ______________________________ **Date:** ______________________

Pharmacy Name: ____________________________________

Pharmacy Phone Number: ____________________________________

Medication or Supplement	Dosage or amount taken	How taken	How often taken
Example: Aspirin	Example: 81 mg	Example: Orally	Example: once a day

I have had allergic reactions to the following drugs:		Drugs	Reaction

I take no medications ____

PASC Folder, ASC Forms, QARM, Patient Medication List Form 03/08jm
PASC, LP, Right Protected

PATIENT'S MEDICARE AUTHORIZATION

PATIENT'S NAME: ____

(FIRST, MIDDLE INITIAL & LAST NAME)

PATIENT'S MEDICARE NUMBER: __ __ __ __ - __ __ __ - __ __ __ __

I request that payment of authorized Medicare benefits be made either to me or on behalf to ***Dr. James F. Zimmermann, Inc.*** for any services furnished me by that physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable to related services.

I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in Item 9 of the HCFA-1500 form or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, co-insurance, and non-covered services. Co-insurance and the deductible are based upon the charge determination of the Medicare carrier.

PATIENT'S
SIGNATURE: ____________________________________ DATE: ___________
OR POA

BARBERTON FOOT & ANKLE James F Zimmermann, DPM

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BARBERTON, OH 44203 - 3651

TELEPHONE (330) 753-7700
FAX (330) 753-3971
EMAIL barbertonfootankle@att.net

DATE: ______________________

ACKNOWLEDGEMENT NOTICE OF PRIVACY PRACTICES

PATIENT'S PRINTED NAME: ____

PATIENT'S SIGNATURE: ____

POA/GUARDIAN SIGNATURE: ____

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BARBERTON FOOT & ANKLE

PRIVACY NOTICE

At ***Barberton Foot and Ankle***, Dr. James F. Zimmermann is committed to treating and using protected health information about you responsibly. This Notice of Privacy Policy describes the personal information we collect, and how and when we use or disclose that information. It describes your rights as they relate to your protected health information. This Notice applies to all protected health information as defined by Federal Regulations.