Patient Information & Health Record

In order to help us render the proper podiatric services to you, please complete this form entirely.
We thank you for your cooperation.

DATE: _____ SOCIAL SECURITY NO:_____/_____/_____ SEX M / F

NAME:_____ Marital Status: ____ Date of Birth ____/____/_____
(If patient is minor, please fill with responsible party information).
Name:_____ HOME PHONE:(____)_____-_____

ADDRESS:_____ CITY: _____ STATE: ____ ZIP: _____

WORK PHONE:(____)_____-_____ extension:_____ CELL PHONE:(_____)_____-_____

EMPLOYER:_____ OCCUPATION:_____

EMPLOYER'S ADDRESS: _____ CITY: _____ STATE: ____ ZIP: _____

SPOUSE'S NAME:_____ Date of Birth: ___/___/___ Work Phone: (___)____-_____
(Or if a child, responsible parent's name)
IN CASE OF EMERGENCY, CONTACT:_____ Phone: (___)____-_____

NEAREST FRIEND OR RELATIVE: _____ Phone: (___)____-_____
(not living with you)
FAMILY PHYSICIAN: _____ Phone: (___)____-_____

PRIMARY INSURANCE INFORMATION

NAME OF CARD HOLDER: _____ Relationship to Patient: _____

NAME OF INSURANCE COMPANY: _____

INSURANCE ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

INSURANCE PHONE: (___)____-_____ EMPLOYER OF CARD HOLDER: _____

POLICY NUMBER ON CARD: _____ GROUP NUMBER (if any): _____
(Including any prefixed- ex. "XWG", "R", "C", without them your claim will be rejected by your insurance co.)
DATE OF BIRTH OF CARD HOLDER: _____/_____/_____

SECONDARY INSURANCE INFORMATION

NAME OF CARD HOLDER: _____ Relationship to patient: _____

NAME OF INSURANCE COMPANY: _____

INSURANCE ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

INSURANCE PHONE: (___)____-_____ EMPLOYER OF CARD HOLDER: _____

POLICY NUMBER ON CARD: _____ GROUP NUMBER (if any): _____

Patient Information & Health Record

How were you referred to our office? _____

Most convenient appointment time? _____

Please describe your foot problem: _____

_____

Have you ever had previous foot care or foot surgery? Yes _____ No _____

*If YES, with whom?*_____ *Date:*_____

GENERAL HEALTH

HEIGHT: _____ *WEIGHT:* _____ *AGE:* _____

Please check any of the following for which you have been or are being treated:

	Arthritis			*Epilepsy*
	Rheumatic Fever			*Asthma*
	Scarlet Fever			*Emphysema*
	Hypertension (hbp)			*Glaucoma / Eye*
	Cardiac Disease			*Venereal Disease*
	Peripheral Vascular Disease			*Hemophilia (bleeding)*
	Tuberculosis			*Renal Disease (kidney)*
	Gout			*Polio, Cerebral Palsy, Muscular Dystrophy*
	Cerebral accidents (stroke)			*Phlebitis / Thrombosis*
	Diabetes			*Thyroid*
	Liver Disease (Hepatitis)			*Anemia*
	Other – Please state:			

ALLERGIES: Are you allergic to any of the following? Please check.

	Penicillin		*Tetracycline*		*Aspirin*
	Sulfa Drugs		*Novacaine*		*Codeine*
	Barbiturates		*Cortisone*		*Iodine Dyes*
	Foods		*Adhesive Tape*		*Other:*
	Environmental		*Caffeine*		

Are you taking any medication? Yes_____ No _____

If YES, Please list: _____

Are you under a Doctor's care at the present time? Yes _____ No _____

Have you had previous surgery or hospitalization? Yes _____ No _____

If YES, Please list – with dates: _____

_____

Foot Centers of Maryland

Dr. Sean Sider and Dr. Jay LeBow

OUR FINANCIAL POLICY: We are pleased that you have chosen us as your podiatric care provider. We are committed to your treatment being successful, and are certain you will be happy with the care provided by our staff. The following is a statement of our financial Policy which we ask that you read and sign PRIOR to any treatment. ALL patients must complete our Patient Information Record before being examined by the doctor.

REGARDING INSURANCE: Your insurance policy is a contract between you and your insurance company. As a convenience to our patients, we submit claims to your insurance company on your behalf. WE CANNOT bill your insurance company UNLESS you bring ALL insurance information (this may include claim forms or referrals). Patients who are in an HMO or PPO program **must present a referral prior to being seen by the doctor**. If you are seen, and it was determined by your insurance carrier that a referral was necessary prior to be seen by one of our doctors, payment by your insurance carrier may be denied and you'll be responsible for payment of services/treatment rendered. Also failure to produce a referral, when necessary, mayl result in a rescheduling of the appointment. If you do not have a referral and you choose to be seen by the doctor, payment in full for that visit/treatment will be required at the time of visit, and you'll have to submit the bill to your insurance company for possible reimbursement.

The insurance industry is changing every day. We will make every effort to assist you, however, it is the patients' responsibility to know and be aware of his/her plan's coverage, deductibles, co-pays, and limitations. If your insurance company should change or if any information pertaining to yourself, your employer, and/or your dependents, it is your obligation to notify us as soon as possible to avoid delays in processing, as we cannot be held responsible.

USUAL AND CUSTOMARY RATES: Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You will be responsible for payments that your insurance company considers to be above the "usual and customary rate". We do require that all co-pays, deductibles, and services not covered by your insurance be paid at the time of service. (This may include post-operative supplies and medications considered "over the counter" items.) If you do not have your copay with you, we reserve the right to either reschedule your appointment or impose a Delayed Payment of Copay Surcharge of $10.00 to your account. We cannot "write off" any amount that is your responsibility.

MISSED APPOINTMENTS: Please help us serve you better by keeping scheduled appointments. If you are unable to keep an appointment, we require that you notify our office at least 24 hours in advance. We reserve the right to charge for appointments not cancelled at least 24 hours in advance.

PAST DUE ACCOUNTS: In the event that your insurance company has not paid your account within 45 days, the responsibility to pay the balance will automatically transfer to you. Please be aware that some or all services provided by our doctors may not be covered and not considered reasonable or necessary under the Medicare Program and/or other insurance plans. Any non-covered services or amounts not paid by your insurance company are due within 30 days of the billing date. An interest charge of 1½ % per month will be added to any unpaid balance of your bill that is 60 days or more overdue. Any account that needs to be rebilled will be charged a Rebilling Finance Charge of $10.00 per month. No Rebilling Charge is added when regular monthly payments of at least $20 are made on your bill. A service charge of $39.00 plus the rebilling fee will be added to your account if your check is returned from your bank for any reason. You are responsible for any fees and costs incurred if your account is turned over to a collections company or an attorney. Any additional medical services will be suspended until your account is paid in full.

Thank you for reviewing our financial policy. Please let us know if you have any questions or concerns.

I have read the Financial Policy. I hereby authorize Foot Centers of Maryland to apply for benefits on my behalf for services rendered by Dr. Sider, Dr. LeBow, or both of them. I request payment to be made directly to Foot Centers of Maryland/ Sean Sider, DPM. I certify the information given is true and correct to the best of my knowledge. I further authorize the release of necessary information, including medical information for this or any other related claim to my insurance company. I permit copy of this authorization to be used in the place of the original. I hereby give permission to Foot Centers of Maryland to examine and treat my feet medically and orthopedically. I understand and acknowledge this statement.

_____ _____

Signature of Patient or responsible party *Date*

_____ _____

Co-responsible party *Date*