

**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: (\_\_\_\_)\_\_\_\_\_-\_\_\_\_\_

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**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

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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: \_\_\_\_\_

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### 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, may 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*