

# WELCOME TO OUR PRACTICE!

**WESTERN OHIO PODIATRIC MEDICAL CENTER**  
**M. Robert Maher, Matthew D. Painting, & Andrew Z. Schwartz**  
**415 West Russ Rd**  
**Greenville, OH 45331**  
**Phone: (937) 548-1244**

## PATIENT INFORMATION: *PLEASE PRINT*

Name \_\_\_\_\_  
Last Name First Name MI

Street Address \_\_\_\_\_ P.O. Box \_\_\_\_\_ Home Phone (\_\_\_\_) \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Cell (\_\_\_\_) \_\_\_\_\_

**Sex:**  M  F **Birthdate:** \_\_\_\_\_ **SS#** \_\_\_\_\_ **Marital Status:**  Single  Married  Widowed

**Preferred Appointment Reminder:**  Text  Call Email, if using our patient portal \_\_\_\_\_

Emergency contact: \_\_\_\_\_ Relationship \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_

**Ethnicity:**  Hispanic/Latino  Not Hispanic/Latino **Race:**  American Indian or Alaska Native  Asian  Black/African American  Native Hawaiian/Other Pacific Island  White

**Advanced Directives:**  None  Living Will  Medical durable power of attorney  other \_\_\_\_\_

**Employment:** Employer \_\_\_\_\_ Business Phone (\_\_\_\_) \_\_\_\_\_  Retired

Work Injury: Is this a work related Injury?  Yes  No Date of Injury: \_\_\_\_\_ Claim #: \_\_\_\_\_

## RESPONSIBLE PARTY INFORMATION

Name (if different from the patient) \_\_\_\_\_ Phone \_\_\_\_\_

Complete Address \_\_\_\_\_

## INSURANCE INFORMATION

*(MUST COMPLETE THIS SECTION, PLEASE)*

**Primary Ins.** \_\_\_\_\_ Subscriber \_\_\_\_\_ DOB \_\_\_\_\_ Relationship \_\_\_\_\_

**Secondary Ins.** \_\_\_\_\_ Subscriber \_\_\_\_\_ DOB \_\_\_\_\_ Relationship \_\_\_\_\_

## ALLERGIES / SENSITIVITIES

**Allergies or Sensitivities to:**  Sulfa  Tape  Latex  Shellfish  Iodine  Seasonal

Medications \_\_\_\_\_  Food \_\_\_\_\_

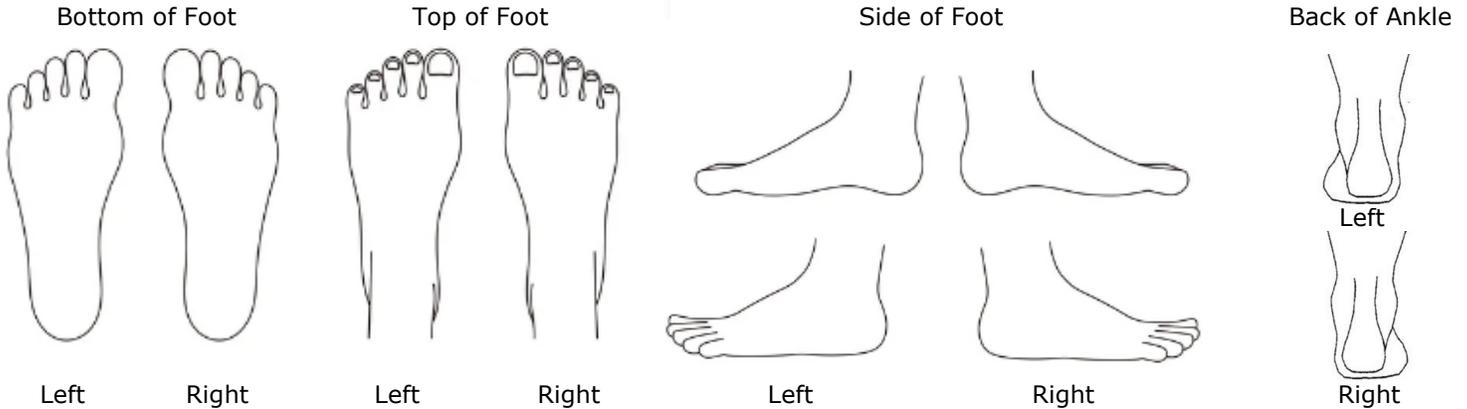
Anesthesia \_\_\_\_\_  None Known

# MEDICAL INFORMATION

Describe Your Foot/Ankle Problem: \_\_\_\_\_

How long have you had this problem? \_\_\_\_\_

Where is the pain/problem located? Please mark on the diagrams below:



How would you rate your pain on a scale from 0 to 10? (Please Circle)

**(No Pain)** 0 1 2 3 4 5 6 7 8 9 10 **(Worst Pain Possible)**

Have you had any past problems/surgical procedures performed on your feet and/or ankles?  Yes  No

If Yes, please list \_\_\_\_\_

Shoe Size \_\_\_\_\_ Current Weight \_\_\_\_\_ Height \_\_\_\_\_

Are you under a physician's care?  Yes  No If Yes, for what condition? \_\_\_\_\_

Name of **Family Physician** \_\_\_\_\_ **Pharmacy** \_\_\_\_\_

May we contact your Family Physician about your health?  Yes  No

Check any of the following problems you have/had:

- |                                     |                                       |  |   |
|-------------------------------------|---------------------------------------|--|---|
| <input type="checkbox"/> Heart      | <input type="checkbox"/> Circulation  | <input type="checkbox"/> Stomach Ulcers      | <input type="checkbox"/> High Blood Pressure            |
| <input type="checkbox"/> Arthritis  | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Healing             | <input type="checkbox"/> Low Blood Pressure             |
| <input type="checkbox"/> Anemia     | <input type="checkbox"/> Blood Clots  | <input type="checkbox"/> Frequent Infections | <input type="checkbox"/> Ulcer/Open Sores               |
| <input type="checkbox"/> Bladder    | <input type="checkbox"/> Lung         | <input type="checkbox"/> Intestines          | <input type="checkbox"/> Neurological                   |
| <input type="checkbox"/> Neuropathy | <input type="checkbox"/> Cancer       | <input type="checkbox"/> Kidneys             | <input type="checkbox"/> Emotional/Psychiatric Disorder |
| <input type="checkbox"/> Skin       | <input type="checkbox"/> Gout         | <input type="checkbox"/> Stroke              |   |
| <input type="checkbox"/> Hormones   | <input type="checkbox"/> Liver        | <input type="checkbox"/> Bleeding Disorder   |   |

Please **clarify** any above checked problems or unlisted problems or illnesses here: \_\_\_\_\_

Do you have **Diabetes**?  Yes (  Type 1  Type 2 )  No

If female, are you **pregnant**?  Yes  No

## MEDICATIONS

Please list all **medications** you take on a regular basis. *(If you have a list of your medications, our office staff will photocopy it.)*

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## SURGICAL HISTORY

Yes  No Have you had any major surgeries? If Yes, please list \_\_\_\_\_

Yes  No Do you have any **Artificial Joints**? If Yes, please list \_\_\_\_\_

Yes  No Do you have a **Heart Valve Implant**?

## FAMILY HISTORY

Unknown, adopted:  Yes  No

Mother History of:

- |   |                                    |  |  |
|---|------------------------------------|--|--|
| <input type="checkbox"/> Heart Disease                          | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Bleeding Disorder | <input type="checkbox"/> Neurological Disorder |
| <input type="checkbox"/> Stroke                                 | <input type="checkbox"/> Bunions   | <input type="checkbox"/> Hammertoes        | <input type="checkbox"/> Flatfeet              |
| <input type="checkbox"/> Circulation problems of the legs/feet? | <input type="checkbox"/> Diabetes  | <input type="checkbox"/> Other: _____      |  |

Father History of:

- |   |                                    |  |  |
|---|------------------------------------|--|--|
| <input type="checkbox"/> Heart Disease                          | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Bleeding Disorder | <input type="checkbox"/> Neurological Disorder |
| <input type="checkbox"/> Stroke                                 | <input type="checkbox"/> Bunions   | <input type="checkbox"/> Hammertoes        | <input type="checkbox"/> Flatfeet              |
| <input type="checkbox"/> Circulation problems of the legs/feet? | <input type="checkbox"/> Diabetes  | <input type="checkbox"/> Other: _____      |  |

Sister(s) History of:

- |   |                                    |  |  |
|---|------------------------------------|--|--|
| <input type="checkbox"/> Heart Disease                          | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Bleeding Disorder | <input type="checkbox"/> Neurological Disorder |
| <input type="checkbox"/> Stroke                                 | <input type="checkbox"/> Bunions   | <input type="checkbox"/> Hammertoes        | <input type="checkbox"/> Flatfeet              |
| <input type="checkbox"/> Circulation problems of the legs/feet? | <input type="checkbox"/> Diabetes  | <input type="checkbox"/> Other: _____      |  |

Brother (s) History of:

- |   |                                    |  |  |
|---|------------------------------------|--|--|
| <input type="checkbox"/> Heart Disease                          | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Bleeding Disorder | <input type="checkbox"/> Neurological Disorder |
| <input type="checkbox"/> Stroke                                 | <input type="checkbox"/> Bunions   | <input type="checkbox"/> Hammertoes        | <input type="checkbox"/> Flatfeet              |
| <input type="checkbox"/> Circulation problems of the legs/feet? | <input type="checkbox"/> Diabetes  | <input type="checkbox"/> Other: _____      |  |

## SOCIAL HISTORY

**Alcohol Use:**  Never  Current  Past What Type?  Beer  Wine  Liquor

**Do you use tobacco products?**  Never  Current  Past If so, what type? \_\_\_\_\_

How many per day? \_\_\_\_\_ How long in use? \_\_\_\_\_ If applicable, how long ago did you quit? \_\_\_\_\_

**Interest in Quitting:**  Yes  No **Concerns about tobacco use in household:**  Yes  No

**Do you use e-cigarettes?**  Never  Yes  No If so, how many per day? \_\_\_\_\_ How long in use? \_\_\_\_\_

**Substance abuse?**  Never  Current  Past How Often? \_\_\_\_\_ If so, what type? \_\_\_\_\_

**Signature** \_\_\_\_\_ **Date:** \_\_\_\_\_

**CONSENT TO TREAT, INSURANCE ASSIGNMENTS, FINANCIAL AGREEMENT, AUTHORIZATION TO RELEASE INFORMATION AND PRIVACY NOTICE ACKNOWLEDGEMENT**

**1. CONSENT TO MEDICAL AND SURGICAL PROCEDURES** The undersigned consents to the medical and surgical care and treatment, as may be deemed necessary or advisable in the judgment of my physician or other provider, which may include but are not limited to laboratory procedures, x-ray examination, medical or surgical treatment or procedures, anesthesia, or other services rendered the patient under the general and special instructions of the patient's physician.

**2. ASSIGNMENT OF INSURANCE BENEFITS AND AUTHORIZATION TO RELEASE INFORMATION** In consideration of services rendered, I hereby transfer and assign to Western Ohio Podiatric Medical Center, Inc. (hereafter referred to as the practice) all rights, title and interest in any payment due to me for services described herein as provided in the above-mentioned policy or policies of insurance. The practice may disclose all or any part of the patient's record (including psychiatric, alcohol and drug abuse, family member or employer of the patient for all or part of the practice's charge, including but not limited to medical service companies, insurance companies, workers compensation carriers, welfare funds or the patient's employer. I further authorize physicians to access my medical prescription history via the Ohio Automated Rx Reporting System (OARRS), if deemed necessary, for my treatment.

**3. FINANCIAL AGREEMENT** The undersigned agrees, whether he/she signs as agent or as patient, that in consideration of the services to be rendered to the patient, he/she obligates himself/herself to pay the account of the practice in accordance with the regular rates and terms of the practice. Should the account be referred to an attorney for collections, the undersigned should pay reasonable attorney's fees and collection expense. The undersigned certifies that he/she has read the foregoing, receiving a copy thereof if requested, and is the patient or is duly authorized by the patient as patient's general agent to execute the above and accepts its terms.

**4. MEDICARE/MEDICAID** Patient's certification authorization to release information and payment request. I certify that the information given to me in applying for payment under Title XVIII/XIX of the Social Security Act is correct. I authorize that any holder of medical or other information about me may release to Social Security Administration/Division of Family Services or its intermediaries or carries any information needed for this or a related Medicare/Medicaid claim. I hereby certify all insurance pertaining to treatment shall be assigned to the practice treating me.

**5. USE OF COPIES** I permit a copy of these authorizations and assignments to be used in place of the original, which is on file at the practice.

**6. PAYMENT RESPONSIBILITY** I understand that certain insurance claims may be filed as a courtesy. However, if a claim is denied for any reason, I am responsible for payment. Insurance is considered a method of reimbursing the physician for services rendered to the patient. Some companies pay fixed allowances for certain procedures, and others pay a percentage of the charges. I understand it is my responsibility to pay any CO-PAY, DEDUCTIBLE, CO-INSURANCE, OR ANY OTHER BALANCE NOT PAID FOR BY MY INSURANCE OR THIRD PARTY PAYOR WITHIN A REASONABLE PERIOD OF TIME NOT TO EXCEED 60 DAYS.

**NOTICE OF PRIVACY PRACTICE ACKNOWLEDGMENT**

I have been given access to on this or a prior occasion the Summary of Notice of Privacy Practices and acknowledge that I have been given a copy, if requested. Received (Access to) Copy This Date: Yes  No  Previously: Yes  No

Patient /Legal Representative: \_\_\_\_\_ Witness: \_\_\_\_\_

Patient unable to acknowledge receipt of the Notice of Privacy  Patient refused to Sign Acknowledgment

Reason: \_\_\_\_\_

DATE: \_\_\_\_\_ PATIENT'S SIGNATURE \_\_\_\_\_

GUARANTOR/GUARDIAN SIGNATURE (if different than patient) \_\_\_\_\_

**WESTERN OHIO PODIATRIC MEDICAL CENTER, INC.**

**RELEASE OF INFORMATION/AUTHORIZATION FORM**

**Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_/\_\_\_\_/\_\_\_\_\_

**RELEASE OF INFORMATION**

I authorize the release of information including the diagnosis, records, examination rendered to me and claims information. This information may be released to:

Name/Relationship \_\_\_\_\_

Name/Relationship \_\_\_\_\_

Name/Relationship \_\_\_\_\_

Information is not to be released to anyone.

This ***Release of Information*** will remain in effect until terminated by me in writing.

**MESSAGES**

Please call:         my home                                 my work                                 my cell

Numbers: \_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_

If unable to reach me:         you may leave a detailed message

please leave a message asking me to return your call

\_\_\_\_\_

**MEDICAL RECORDS FAX TRANSMISSION AUTHORIZATION**

I understand that you will be transmitting my medical records electronically and authorize you to do so, limited to physicians and insurance companies. If another party in error receives them, I absolve Western Ohio Podiatric Medical Center and its physicians of any and all liability relating to such submission of said records. **(Please check one)**  Yes     No

**Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_

**Witness:** \_\_\_\_\_

**Date:** \_\_\_\_\_

**WESTERN OHIO PODIATRIC MEDICAL CENTER, INC.**

**Consent to Photograph**

**Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_/\_\_\_\_/\_\_\_\_\_

“I understand that photographs, videotapes, digital, or other images may be recorded to document my care, and I consent to this. I understand that Western Ohio Podiatric Medical Center, Inc will retain ownership rights to these photographs, videotapes, digital, or other images, but that I will be allowed access to view then or obtain copies. I understand that these images will be stored in a secure manner that will protect my privacy and that they will be kept for the time period required by law or outlined in Western Ohio Podiatric Medical Center’s policy. Images that identify me will be released and/or used outside the institution only upon written authorization from me or my legal representative.”

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

*Note: This consent does not authorize the use of images for the other purpose, such as teaching or publicity. A separate consent for photography for should be used for such purposes.*