DELTA FOOT AND ANKLE

PLEASE PRINT INFORMATION CLEARLY

Patient Name_____ Date of Birth_____

Phone_____ Email_____

Address_____

City, State_____ Zip Code_____

Weight _____ Height_____ SSN_____

Occupation_____ Employer_____

Employer Address_____ Phone_____

Marital Status_____ Spouse/Parent_____

Spouse/Parent Employer_____ Phone_____

Person responsible for bill_____ Relationship_____

How did you hear about us? Please include a name if someone referred you to us.

_____

FINANCIAL POLICY

All office visits and procedures are handled on a cash basis at the time services are provided. For your convience, you may pay by cash, personal check, or card. Methods of payment other than these must be discussed with the Office Manager.
All accounts are subject to a 1.5% per month (18% APR) finance charge after 30 days of inactivity. Collection and attorney fees will be charged to your account if legal action is required.
*We are participating providers with several PPO, HMO, and other third-party plans. If you are covered by one of these plans, please let us know on your first visit. Also, please bring the necessary forms and identification cards needed to process these claims.

Signature_____ Date_____

DELTA FOOT AND ANKLE

PLEASE PRINT INFORMATION CLEARLY

Medical Information:

Primary Care Doctor_____ Last visit_____

Podiatrist_____ Last visit_____

Are you Diabetic?_____ Do you have a family history of Diabetes?_____

Have you been treated for any of the following? Please check all that apply:

Heart/Circulation		Orthopedic		Psychiatric	
Respiratory		Skin		Allergies	
Stomach/Colon		Neurological		Cancer	

List and surgeries or complications in the last 10 years:

_____

_____

Current medications:

_____

_____

Describe your current foot problem and any treatment you have received for this condition in the past:

_____

_____

_____

Allergies:_____

Pharmacy: _____

DELTA FOOT AND ANKLE

PLEASE PRINT INFORMATION CLEARLY

ACKNOWLEDGEMENT:

NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Notice of Privacy Practices and I have read (or had the opportunity to read if I so choose) and understand the Notice.

_____ _____

Patient Name (Print) Date

_____

Parent or Guardian Name (Print)

_____

Signature of Patient (or Parent/Guardian)