WELCOME TO OUR PRACTICE!

WESTERN OHIO PODIATRIC MEDICAL CENTER
C. David Trimble, M. Robert Maher,
Jennifer S. Stevens, Matthew D. Painting
415 West Russ Rd
Greenville, OH 45331
Phone: (937) 548-1244

Please fill in all areas-If not applicable please write N/A

PATIENT INFORMATION: **Patient #** _____

PLEASE PRINT **(office use only)**

Name _____
Last Name First Name MI

Address _____ Home Phone (_____)_____

Email _____ Cell or alternate phone (_____)_____

City _____ State _____ Zip _____

Birthdate _____ SS# _____ Sex: ☐ M ☐ F

Is this a work related Injury: _____ Date of Injury: _____

Employer _____ Business Phone (_____)_____

Business Address _____ Occupation _____

In case of emergency, who should we contact? _____
Relationship _____ Phone (_____)_____

RESPONSIBLE PARTY / INSURANCE INFORMATION

Primary Card Holder Name_____

Primary Insurance SS# _____

Primary Insurance **Birthdate** _____

Relationship to Patient _____

Address _____

Home Phone _____

City _____ State _____ Zip _____

Employer _____

Business Address _____

Business Phone _____

Secondary Card Holder Name_____

Secondary Insurance SS# _____

Secondary Insurance **Birthdate** _____

Relationship to Patient _____

Address _____

Home Phone _____

City _____ State _____ Zip _____

Employer _____

Business Address _____

Business Phone _____

Please provide the office staff with your insurance cards so we may photocopy them for pertinent insurance information.

ASSIGNMENT AND RELEASE

I hereby authorize payment directly to Western Ohio Podiatric Medical Center, Inc. for all insurance benefits. **I understand that I am financially responsible for any portion of the charges, whether or not paid by insurance,** and for all services rendered on my behalf or my dependent(s). I agree to make full and complete payment within 45 days of denial of a claim by the insurance company.

I authorize the above provider or supplier of services in this office to release any information required to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

I understand all of the above and hereby state that the information is correct to the best of my knowledge

Signature of Responsible Party _____ **Date** _____

MEDICAL INFORMATION

Describe Your Foot/Ankle Problem: _____

How long have you had this problem? _____

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

If Yes, please list _____

Shoe Size _____ Current Weight _____ Height _____

☐ Yes ☐ No Do you have **Diabetes**? If Yes, do you take insulin? ☐ Yes ☐ No Number of Years? _____

☐ Yes ☐ No Have you had any serious illnesses/major surgeries?

If Yes, please list _____

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

Family Physician name, phone and address _____

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

Name of Preferred Pharmacy _____ Phone (_____)_____

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

_____

Check any of the following you have, or have had a problem with:

☐ **Heart**	☐ Skin	☐ Circulation	☐ Stomach Ulcers	☐ Gout
☐ Arthritis	☐ Hormones	☐ Tuberculosis	☐ Healing	☐ Kidneys
☐ Anemia	☐ Liver	☐ Rheumatic Fever	☐ Lungs	☐ Frequent Infections
☐ Bladder	☐ Spleen	☐ Cancer	☐ High BP	☐ Intestines
☐ Neurological Disorder		☐ Asthma/Breathing Difficulty		☐ Eye, Ear, Nose or Throat
☐ Emotional/Psychiatric Disorder		☐ Unexplained Fever/Weight Loss		☐ **Bleeding Disorders**

☐ Yes ☐ No Do you have any **Artificial Joints**?

If Yes, please list _____

☐ Yes ☐ No Do you have a **Heart Valve Implant**? If female, are you pregnant? ☐ Yes ☐ No

ALLERGIES / SENSITIVITIES

Please list any **allergies and/or sensitivities** you may have: _____

_____

☐ Yes ☐ No Are you allergic or sensitive to tape?

☐ Yes ☐ No Do you have problems with local anesthetics (Novocaine, Lidacaine)?

SOCIAL HISTORY

☐ Yes ☐ No Do you use tobacco products? If so, what type:_____ How many per day? _____

☐ Yes ☐ No Did you previously? How long was use? _____ How long ago did you quit? _____

☐ Yes ☐ No Do you drink alcohol? What type? _____ How often? _____

Employment: ☐ Sit at Job ☐ Stand at Job ☐ Stand and Walk at Job ☐ Retired

Student: ☐ Full-time ☐ Part-time ☐ N/A

Marital Status: ☐ Single ☐ Married ☐ Other

Primary Language: _____

Ethnicity: ☐ Hispanic/Latino ☐ Not Hispanic/Latino

Race: ☐ American Indian or Alaska Native ☐ Asian ☐ Black/African American

☐ Native Hawaiian or Other Pacific Island ☐ White ☐ Other _____

Signature _____ **Date** _____

FAMILY HISTORY

Mother ☐ Living ☐ Deceased Cause of Death: ☐ Natural ☐ Other _____

History of:

☐ Heart Disease ☐ Arthritis ☐ Bleeding Disorder ☐ Neurological Disorder
☐ Stroke ☐ Bunions ☐ Hammertoes ☐ Flatfeet
☐ Circulation problems of the legs/feet? ☐ Other: _____

Father ☐ Living ☐ Deceased Cause of Death: ☐ Natural ☐ Other _____

History of:

☐ Heart Disease ☐ Arthritis ☐ Bleeding Disorder ☐ Neurological Disorder
☐ Stroke ☐ Bunions ☐ Hammertoes ☐ Flatfeet
☐ Circulation problems of the legs/feet? ☐ Other: _____

Brother(s) ☐ Living ☐ Deceased Cause of Death: ☐ Natural ☐ Other _____

History of:

☐ Heart Disease ☐ Arthritis ☐ Bleeding Disorder ☐ Neurological Disorder
☐ Stroke ☐ Bunions ☐ Hammertoes ☐ Flatfeet
☐ Circulation problems of the legs/feet? ☐ Other: _____

Sister(s) ☐ Living ☐ Deceased Cause of Death: ☐ Natural ☐ Other _____

History of:

☐ Heart Disease ☐ Arthritis ☐ Bleeding Disorder ☐ Neurological Disorder
☐ Stroke ☐ Bunions ☐ Hammertoes ☐ Flatfeet
☐ Circulation problems of the legs/feet? ☐ Other: _____

Is there any other family (blood relative) with a history of:

☐ Heart Disease-Who? _____ ☐ Arthritis-Who? _____
☐ Bleeding Disorder-Who? _____ ☐ Neurological Disorder-Who? _____
☐ Stroke-Who? _____ ☐ Bunions-Who? _____
☐ Hammertoes-Who? _____ ☐ Flatfeet-Who? _____
☐ Circulation problems of the legs/feet? -Who? _____
☐ Other and Whom: _____

_____

_____

_____

Signature _____ **Date** _____