

WELCOME TO OUR PRACTICE!

WESTERN OHIO PODIATRIC MEDICAL CENTER

C. David Trimble ♦ M. Robert Maher
Jennifer S. Stevens
415 West Russ Rd
Greenville, OH 45331

PATIENT INFORMATION:

Patient # _____

Name _____
Last Name First Name MI
Address _____ Home Phone (_____) _____
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 _____
Who should we thank for referring you? _____
In case of emergency, who should we contact? _____
Relationship _____ Phone (_____) _____

RESPONSIBLE PARTY / INSURANCE INFORMATION

Primary Insurance Name _____	Secondary Insurance Name _____
Primary Card Holders Name _____	Secondary Card Holders Name _____
Primary Insurance SS# _____	Secondary Insurance SS# _____
Primary Insurance Birthdate _____	Secondary Insurance Birthdate _____
Relationship to Patient _____	Relationship to Patient _____
Address _____	Address _____
Home Phone _____	Home Phone _____
City _____ State _____ Zip _____	City _____ State _____ Zip _____
Employer _____	Employer _____
Business Address _____	Business Address _____
Business Phone _____	Business Phone _____

** If applicable, please provide the office staff with your insurance cards so we may photocopy them for pertinent information.*

ASSIGNMENT AND RELEASE

I hereby authorize payment directly to Western Ohio Podiatric Medical Center, Inc. (Drs. C. David Trimble, M. Robert Maher and Jennifer S. Stevens) 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 doctor(s) and/or any 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 _____

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)?

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:

- | | | | | |
|---------------------------------------------------------|-----------------------------------|--------------------------------------------------------|-----------------------------------------|----------------------------------------------------|
| <input type="checkbox"/> Heart | <input type="checkbox"/> Skin | <input type="checkbox"/> Circulation | <input type="checkbox"/> Stomach Ulcers | <input type="checkbox"/> Gout |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Hormones | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Healing | <input type="checkbox"/> Kidneys |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Liver | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Lungs | <input type="checkbox"/> Frequent Infections |
| <input type="checkbox"/> Bladder | <input type="checkbox"/> Spleen | <input type="checkbox"/> Cancer | <input type="checkbox"/> High BP | <input type="checkbox"/> Intestines |
| <input type="checkbox"/> Neurological Disorder | | <input type="checkbox"/> Asthma/Breathing Difficulty | | <input type="checkbox"/> Eye, Ear, Nose or Throat |
| <input type="checkbox"/> Emotional/Psychiatric Disorder | | <input type="checkbox"/> Unexplained Fever/Weight Loss | | <input type="checkbox"/> 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

SOCIAL HISTORY

Yes No Do you smoke? # of packs per day? _____ Previously smoked? Yes No # of years? _____

Yes No Do you drink alcohol? Light Usage (1-2/week) Moderate Usage (1-2/day) Heavy (2+ daily)

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

FAMILY HISTORY

Mother Living Deceased Cause of Death: Natural Other _____

Father Living Deceased Cause of Death: Natural Other _____

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

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

Is there a family (blood relative) with a 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? | | | |

Signature _____ **Date** _____