Corrigan Podiatry

Patient Information Sheet

Welcome to our Office…

***Attention*: Please fill out this form COMPLETELY, write N/A where applicable and sign it. Thank you.**

Social Security#

First Name: ______ **Last Name:** ______ **Middle Initial:** ______

Date of Birth: (MM/DD/YYYY) ______ / ______ / __________

Gender: ☐ Male ☐ Female

Marital Status: ☐ Single ☐ Married ☐ Other

Address: ______ **Apt.#:** ______ **City:** ______ **State:** ______ **Zip:** ______

Home Phone: (______) ______ **Work Phone:** (______) ______ **Cell Phone:** (______) ______

Emergency Contact: ______ **Emergency Telephone#:** (______) ______

Employer Name: ______ **Employer's Address / City / State / Zip** ______

Referring Doctor: ______ **Referring Dr.'s Address / City / State / Zip** ______ **Ref. Dr. NPI #** ______

Primary Care Physician: ______ **Primary Care Physician's Address / City / State / Zip** ______ **P.C.P. NPI #** ______

Primary Insurance Company Information:

Policy Holder First Name: ______

Policy Holder Last Name: ______

Policy Holders SS# _______-______-____________ **Policy Holders Date of Birth:** _____ / ______ / ______

Gender: ☐ Male ☐ Female **Relationship to Policy Holder:** ☐Self ☐Spouse ☐Child ☐Other

Policy Holder's Address: ☐ **Same as patient**

______

City: ______ **State:** ______ **Zip:** ______

Insurance's Name: ______

Policy ID: ______ **Group #:** ______

Claim Submission Address: ______

Effective Date: ______ / ______ / ________

Do you have a Co-pay? ☐ No ☐ Yes, Amt $_______

Referral Required: ☐ **Yes** ☐ **No**

Secondary Insurance Company Information:

Policy First Name: ______

Policy Holder Last Name: ______

Policy Holders SS# _______-______-____________ **Policy Holders Date of Birth:** _____ / ______ / _______

Gender: ☐ Male ☐ Female **Relationship to Policy Holder:** ☐Self ☐Spouse ☐Child ☐Other

Policy Holder's Address: ☐ **Same as patient**

______

City: ______ **State:** ______ **Zip:** ______

Insurance's Name: ______

Policy ID: ______ **Group #:** ______

Claim Submission Address: ______

Effective Date: ______ / ______ / ________

Do you have a Co-pay? ☐ No ☐ Yes, Amt $_______

Referral Required: ☐ **Yes** ☐ **No**

Responsible Party Information – *Please complete if the responsible for payment is not the Patient or the Policy Holder.*

Responsible Party's Name (Last / First): ______

Responsible Party's SSN: _______-______-____________

Relationship to Responsible Party: ☐Self ☐Spouse ☐Child ☐Other

Responsible Party's Address / City / State / Zip: ______

FINANCIAL POLICY

I hereby authorize the release of any medical information necessary to process this claim and hereby assign to the physician all payments for medical services rendered to my dependents or myself. I understand that it is as a courtesy that the doctor accepts my insurance for payment and that if for any reason they do not pay my bill that I am responsible.

The Practice accepts personal checks. In the event that a check 'bounces' (i.e., insufficient funds exist to cover the check), a fee of $25 will be applied.

All patients receive a reminder call for upcoming appointments. Failure to appear or call to cancel 24hrs prior to an appointment (no show) will result in a $25 fee.

By signing below, I acknowledge and agree to abide by this policy. I also acknowledge that I have been given the opportunity to review the Health Insurance Portability and Accountability Act (HIPPA) Notice of Privacy Practices and I agree to comply with all of its terms.

Today's Date:________________ Patient's Signature (or parents if under 18 years of age): ____________________________

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PATIENT NAME: ______________________ ***Please fill out completely***

Family Doctor's Name______________________________ Date Last Seen__________________

Medications Currently Taking:____

Drug Allergies____ NONE

Major Illnesses(Past/Present)____

Past Surgeries____

Current Pharmacy and Location ____

Height ____________ **Weight** ______________

Referred by: Website ____ **Office Sign** ____ **Person** ____ **Name:** ______________________

Current Podiatric Problem:

What is the specific complaint today?____

How long has it been a problem?____

What have you done to treat the problem so far?________________________________

Have you ever been cared for by a foot doctor? **Yes No** When:______________________________

Health History:

____ Diabetes
If so, Endocrinologist?
____
Eye Doctor?
____
____ Poor Circulation
____ Heart Disease
____ High Blood Pressure
____ Previous Ulcers
____ Arthritis
____ Phlebitis

____ Muscle Problems
____ Liver Disease
____ Immune Compromised
____ Bone Problems
____ Skin Disease
____ Stomach Disorders
____ Lung Disease
____ Cancer
____ Headaches
____ Eye Disease

Do you smoke?
____ Yes ____NO _____ I Quit

Do Small cuts/bruises heal easily?
____ Yes ____ NO

Are you currently Pregnant?
____ Yes ____ NO
If yes, when are you due? ______
Complicated Pregnancy? ______

Family History of:	No	Yes	Relative
Anesthesia problem	O	O	
Bleeding disorder	O	O	
Cancer	O	O	
Heart Disease	O	O	
Diabetes	O	O	
High blood pressure	O	O	
Seizure	O	O	
Stroke	O	O	
Substance abuse	O	O	

I, hereby, give permission to Dr. Tom Corrigan or designated medical professionals to access and treat my feet/lower extremities using any and all medical, surgical or orthopedic methods appropriate. I am aware that Corrigan Podiatry has a posted irrevocable narcotics policy. **I realize it is my responsibility to research and comprehend my individual medical insurance, including copays, deductibles, and benefits/exclusions of the plan. I am financially responsible for all charges until my deductible is met.**

______________________________ ______________

Signature Date