



MEDICAL HISTORY AND PATIENT INFORMATION
Please print clearly!

NAME: _____ Date of birth: _____ Sex: M F

ADDRESS: _____ SSN: _____ - _____ - _____
^^^ -required to verify insurance
Driver's License: State _____ #: _____

EMAIL*: _____
^^^required for all office communication

MOBILE PHONE: _____
HOME PHONE: _____

PRIMARY CARE PHYSICIAN: _____ DATE OF LAST VISIT: _____

Who referred you to our office? _____

IN YOUR WORDS, WHAT PROBLEM ARE YOU HAVING TODAY? _____

BEST ESTIMATE FOR YOUR: HEIGHT: _____ WEIGHT: _____

ALLERGIES: Are you allergic to any of the following? [] I have no known allergies
[] Aspirin [] Latex [] Penicillin [] Sulfa [] Eggs
[] Iodine [] Local anesthetics [] Codeine [] Tetracycline [] Bee stings
[] Cipro [] Clindamycin [] Other: _____

MEDICATIONS: Please list any medications and dosages taken, include over the counter medications, vitamins, & herbal medications

> PREFERRED PHARMACY: _____

MEDICAL PROBLEMS: Please check box if you are currently being treated for any of the following:
[] Blindness [] Asthma [] Arthritis [] Hypothyroidism
[] Cataracts [] Bronchitis [] Gout [] Thyroid disease
[] Glaucoma [] COPD [] Bone/Joint injury [] Diabetes type (1) [] type (2) []
[] Seasonal allergy [] Pneumonia [] Dermatitis [] Anemia
[] Aneurysm [] Cirrhosis [] Seizure [] AIDS/HIV
[] Chest pain/ Angina [] Reflux/GERD [] Migraine headaches [] Hepatitis
[] High blood pressure [] Gall bladder disease [] UTI [] Tuberculosis
[] High cholesterol [] Ulcer [] Kidney disease [] Liver disease
[] Hernia [] Other medial problems not listed: _____
[] I do not have significant medical problems.

MEDICAL HISTORY: Please check if you have been treated for the following:
[] Stroke [] Heart attack [] Blood clots/ DVT [] Cancer _____

PRIOR SURGERIES: Please list any surgeries, including previous foot surgery.

SOCIAL HISTORY:
[] Never smoked [] Do not drink alcohol [] Other
[] Everyday smoking [] Daily alcohol [] Explain: _____
[] Former smoker [] Occasional alcohol



FINANCIAL POLICY AND PATIENT PAYMENT AGREEMENT

Our financial relationship is with **you**, the patient.

You, not your insurance company, are ultimately responsible for the payment of all fees charged.

For your convenience we accept credit card payment for amounts greater than \$5.00.

We request that you pay your estimated portion at the time of service.

If we cannot verify eligibility from your insurance carrier, payment is due in full at the time of treatment.

Our office does not extend payment plans. You are responsible for all collection fees and any other expenses incurred to collect unpaid accounts. Outstanding balances greater than 90 days will be sent to professional collection agents and the patient will be discharged from the practice.

Credit cards are kept on file for payments and outstanding balances which are not paid at the time of service:

MEDICAL PRACTICE: Exeter Foot & Ankle Center

Patient name: _____

Type of credit card: [] MasterCard [] Visa [] Discover [] Amex

Name as it appears on card: _____

Card # _____ - _____ - _____ - _____ expiration _____ - _____ cvv: _____ billing zip code: _____

I, _____ authorize Exeter Foot & Ankle Center to process the above credit card as "card on file."
I understand this authorization will remain in effect until the expiration of the credit card account. Patient may also revoke this authorization by submitting a written request to the medical practice.

Failure to keep your health insurance current, including coordination of benefits with multiple insurance companies, results in patient responsibility of payment. Account balance/deductible not settled at the time of service may be billed to card on file. Any remaining balance after your insurance company issues payment is due upon receipt of your billing statement.

There will be a **\$20.00** charge for a missed appointment or for failing to cancel 48 hours in advance.

Any cancellation or reschedule made less than 2 business days will result in a cancellation fee. Anything less than 2 business days does not allow adequate time to call patients on our waiting list to offer sooner appointments. _____, (initial)

In the event of a true, unavoidable emergency, all or part of your cancellation fee may be applied to future services.

I certify the above information is true and correct to the best of my knowledge.

I give permission to the doctor to administer and perform such procedures as may be deemed necessary in the diagnosis and/or treatment of my feet.

Patient signature: _____ Date: _____

Name of responsible party if other than patient: _____ Relationship: _____

Signature of responsible party: _____ Date: _____

PRIMARY INSURANCE ACCOUNT: [] Patient [] Parent [] Spouse [] Guardian [] other _____

> If other than Patient then complete for the primary account:

Insurance company/plan: _____ Member ID number: _____

NAME: _____ Date of birth: _____ Sex: M F

ADDRESS: _____ SSN: _____
^^^ -required to verify insurance