

WELCOME TO OUR OFFICE

Name _____ Social Sec. # _____

Home Address _____ City _____

State ____ Zip _____ Home Phone _____ Cell Phone _____

Male ____ Female ____ Married ____ Single ____ Student: Full-time ____ Part-time ____

Date of Birth _____ Age _____

Employer _____ How long? _____

Occupation _____ Work Phone _____ Ext _____

Emergency Contact _____ Phone _____

Family Physician _____ Address/Phone _____

How did you hear about our office? _____

INSURANCE INFORMATION

Primary Insurance: _____ Co-pay _____

Policyholder Name _____ ID # _____

Date of Birth _____ Insured Employer _____ Phone _____

Secondary Insurance _____ Co-pay _____

Policyholder Name _____ ID # _____

Date of Birth _____ Insured Employer _____ Phone _____

I hereby authorize Central Ohio Podiatry Group, to submit a claim to my insurance carrier for all covered services rendered by the physician(s) and authorize and direct my insurance carrier or its intermediaries to issue payment checks directly to the physician(s) rendering the covered service. I will be responsible for those charges deemed not covered by said insurance carrier so long as such insurance has not deemed such services to be medically inappropriate or unnecessary. I also understand that if my insurance company is not a contracted carrier, I am responsible for the full fee charged by my physician(s) regardless of what my insurance pays. I authorize COPG to furnish complete information to my insurance carrier and its intermediaries regarding the serviced rendered. I permit a copy of this authorization to be used in place of the original.

Responsible party's signature

Date

GENERAL HEALTH

NAME _____ DATE _____

1. What are your present foot problems? _____

How long? _____

2. Please list any medical conditions, **past and present**. Ex: Mitral Valve Prolapse, diabetes, hepatitis, HIV, anemia, stroke, blood clots, poor circulation, thyroid disease, hypertension, epilepsy, heart disease: MI, angina, dyspnea, or lung disease: asthma, emphysema, sleep apnea, and any past **MRSA** infections, etc.

3. Please list any operations that you have had. _____

4. Please list all prescription and non-prescription medications you are currently on: _____

5. Please list all medications that you are allergic to: Ex: Demerol, Codeine, certain antibiotics (PCN, Erythromycin, Sulfa), Novocain, **latex**, etc _____

6. Height _____ Weight _____ Shoe Size _____

7. **Women only:** Is there any possibility you could be pregnant? Yes No
Date of last menstrual period? _____

SOCIAL HISTORY

1. Do you smoke? Yes No How many packs per day? _____ Quit, when? _____

2. Please indicate how much alcohol you consume: None _____ Beers per week _____
Glasses of wine per week _____ Glasses of liquor per week _____

FAMILY HISTORY

Please circle Yes or No if the following ailments apply in your family history:

heart disease	Yes	No	seizures/epilepsy	Yes	No	cancer	Yes	No
thyroid disease	Yes	No	tuberculosis	Yes	No	ulcer	Yes	No
muscle disease	Yes	No	cholesterol	Yes	No	stroke	Yes	No
mental illness	Yes	No	arthritis/gout	Yes	No	diabetes	Yes	No
lung disease	Yes	No	hypertension	Yes	No	panic attacks	Yes	No

**CENTRAL
OHIO
PODIATRY
GROUP, Inc.**

Excellence in foot & ankle care since 1948

Jack H. Buchan, D.P.M., FACFAS
David S. Buchan, D.P.M., FACFAS
Diplomates, American Board of Podiatric Surgery
Fellow, American College of Foot Surgeons
Randall J. Contento, D.P.M

PRIVACY CONSENT AND ACKNOWLEDGEMENT OF MEDICAL PRIVACY NOTICE

This consent is required by the Health Insurance Portability and Accountability Act of 1996 to inform you of your rights for privacy with respect to your health care information.

Consent for care: I, with my signature, authorize COPG, and any employee working under the direction of the physician, to provide medical care for me, or to this patient for which I am the legal guardian. This medical care may include services and supplies related to my health (or the identified person) and may include (but limited to) preventive, diagnostic, palliative care, counseling, surgical, dispensing of drugs, devices, equipment or other items required and in accordance with a prescription. This consent includes contact and discussion with other health care professionals for care and treatment.

Consent for release of information: I also authorize this practice to furnish information of the identified insurance carrier(s) for any and all payment activities. I further consent to the use for any practice operational needs as identified in the Medical Privacy Notice.

Consent for assignment of benefits: I consent to assign all payments for these services to this practice. I understand that I am responsible for all co-payments, amounts applied to deductibles and any co-insurance amounts, as required by my contract with my insurance plan and state regulation. I further understand that my contract with my insurance entity may or may not cover some services. It is my responsibility to obtain information from my health plan about service coverage. If I seek care outside of the contract, I am aware that I may be responsible for all charges that are incurred.

Consent and acknowledgement of Medical Privacy Notice: I have had a chance to review the Medical Privacy Notice as part of this registration process. I understand that the terms of the Privacy Notice may change and I may obtain these revised notices by contacting the practice by phone or in writing. I understand I have the right to request how my protected health information (PHI) has been disclosed. I also have the right to restrict how this information is disclosed, but this practice is not required to agree to my restrictions. If it does agree to my restrictions on PHI use, it is bound by that agreement.

I understand that this practice may refuse me services if I refuse to sign this consent. I may revoke this consent at any time, but the practice may refuse further services at that time.

Patient/Guardian: _____ Date: _____

Name Printed: _____ If not patient, relationship: _____

Patient Account #: _____

BUSINESS ADDRESS:
550 S. CLEVELAND AVE. SUITE B WESTERVILLE, OHIO 43081-3898
614-890-7224 FAX 614-890-8253
800-550-2201
OFFICES ALSO IN DUBLIN AND LANCASTER

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