



The Foot Doctor, P.C.
Michael P. Wilkinson, DPM
Daniel T. Jones, DPM
2233 E. 2nd St.
Casper, WY 82609
P: 307-237-3668
F: 307-237-1180
www.wyofootdoctor.com

PLEASE RETURN THE FOLLOWING PAPERWORK WITHIN ONE BUSINESS DAY OF YOUR APPOINTMENT

Thank you for your interest in The Foot Doctor. We look forward to handling all of your foot care needs. Please take a minute to read an overview of our office policies and procedures.

Co-payment and any OTC product charges are expected at the time of your visit, unless other arrangements have been made prior to your appointment. We realize that some of our patients carry Medicare insurance and though they do cover many procedures, there are some charges they do not cover. If you have any questions feel free to call the office and ask if your procedures are covered in full.

As a courtesy to our patients we do bill primary and secondary insurance. It is the patient's responsibility to follow up with their insurance company to identify any reimbursement problems. While we will gladly help resolve insurance reimbursement issues, this does not mean payment is not required until your insurance pays.

We are providers for Cigna, Medicare, Blue Cross Blue Shield, and Blue Cross Blue Shield Kid Care CHIP ONLY. If your primary insurance is Medicaid (Title 19), the state of Wyoming does not cover podiatry services provided by a specialist. If you have Medicaid as your primary, we can treat you, but on a cash basis and you will be responsible for any and all charges. Medicaid will pay for charges if they are secondary to your primary Medicare insurance.

For cash patients only, we offer a 10% discount if the charges for that day are paid in full at the time of check out. A payment agreement will be provided for any patient that cannot pay their bill in full. This agreement must be signed and satisfactory monthly payments must be received in a timely manner. Failure to comply with the financial agreement will result in a **10-day notice to pay your account in full or be turned over to collections.**

We accept cash, checks, MasterCard, Visa, American Express, and Discover.

Tardiness makes the whole office fall behind. Please be respectful, and be timely for your appointment. We require a 24 hour notice of cancellation. Because we call the day before your appointment to remind you of your appointment, failure to give notice will result in a \$25.00 "No Show" fee.

Patients coming from out of town, please bring 3-5 pairs of shoes that you frequently wear to your first visit.

Please feel free to call us if you have any questions regarding this or other information.

Thank you!

OVER >

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Dear New Patient,

Please complete the following for our records. Thank you!

Where did you hear about the Foot Doctor? (PLEASE CHECK ALL THAT APPLY)

Doctor _____ Who? _____

Friend _____

Family Member _____

Internet _____

Newspaper _____

Phonebook _____

Billboard _____

Health Fair _____

Radio _____

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PATIENT INFORMATION

Name Last First Middle Initial Gender: Male Female
S.S.N. Date of Birth Age
Mailing Address City/State/ZIP
Home Phone Cell Phone
E-mail Address:
Employer Address Phone
Marital Status: Single Married Widowed Separated Divorced
Race: Am.Indian/Alaskan Native Asian Black White Pacific Islander Other Declined
Ethnicity: Hispanic Non-Hispanic Declined
Emergency Contact: Relationship: Phone:
Primary Care Physician: Referring Physician(if different from Primary Care):
Pharmacy:

RESPONSIBLE PARTY (if different from patient)

Name Relation to Patient
Mailing Address City/State/ZIP
S.S.N. Date of Birth Home Phone Cell Phone
Employer Work Phone

INSURANCE INFORMATION

Primary Insurance ID Number Group Number
Secondary Insurance ID Number Group Number
Policy Holder Name Relation to Patient
Policy Holder S.S.N. Policy Holder Date of Birth
Policy Holder Employer Work Phone

Communication/Release of Information:

I wish to be contacted in the following manner (check all that apply):

Telephone numbers: You may leave detailed messages. OR You may leave a call-back number only.
Written communication to the above mailing address. You may fax to
Email to the address above (Used for Secure Messaging)

You may speak to and release information to the following individuals regarding my healthcare (name and relation):

I understand that I am legally and financially responsible for all charges whether or not they are paid by the stated insurance. I authorize the release of any information necessary to determine liability for payment. I also authorize release of information to my primary doctor, spouse, other family members stated above, as well as my insurance company. (If there is anyone you do not wish information to be released to, please state below.) I request that payment of benefits be made to the provider on my behalf. This assignment will remain in effect until revoked by me in writing. If this account is assigned to an attorney for collection and/or suit, the practice shall be entitled to reasonable attorney's fees and cost of collection. I give my permission to Dr. Wilkinson or Dr. Jones to administer and perform such procedures deemed necessary, by me, in the diagnosis and/or treatment of my (or my child's or my parent's) feet. If I am a Medicare patient, I understand that there are certain charges that are Non-Covered by Medicare and am willing to continue with the procedure.

Patient or Guardian Signature

Relationship

Date

The Foot Doctor, PC

Do you currently **use tobacco/e-cigarettes**? Yes No Did you ever smoke? Yes No
 (Please indicate type of tobacco, amount per day, number of years, and quit date.)

Do you currently **drink alcohol**? Yes No How many drinks per week? _____

Shoe Size: _____ Shoe Width: N M W WW

Athletic Activities: _____

Do you have any **ALLERGIES** to MEDICATIONS? Yes No

If yes, please list medications and reactions: _____

MEDICATIONS AND SUPPLEMENTS-

Please check the box if you are **NOT** currently taking any medications or supplements

Please list ALL of your CURRENT medications and supplements below
 (if you need more room, please use the back page):

| Medication Name | Amount | Take | Frequency Taken (daily, every 6hrs, etc.) |
|----------------------------|--------------|--------------|-------------------------------------------|
| <i>Example: metoprolol</i> | <i>25 mg</i> | <i>1 TAB</i> | <i>Once daily</i> |
| | | | |
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PAST MEDICAL HISTORY

Do **you** personally have a history of:

| Issue | YES | NO | Issue | YES | NO |
|---------------------------------------|-----|----|-------------------------|-----|----|
| Diabetes Type I? or Type II? | | | Heart Disease | | |
| Gout | | | Hepatitis | | |
| Aids/HIV | | | High Blood Pressure | | |
| Anemia | | | High Cholesterol | | |
| Arthritis Rheumatoid or Osteo? | | | Hyperthyroidism | | |
| Artificial Heart Valve | | | Hypothyroidism | | |
| Artificial Joints | | | Jaundice | | |
| Back Problems | | | Kidney Disease | | |
| Bleeding Disorders | | | MRSA | | |
| Cancer - What Kind? | | | Respiratory Disease | | |
| Circulatory Problems | | | Stroke | | |
| Dementia | | | Unexplained Weight Loss | | |
| GERD (G.I.Reflux) | | | Other | | |

PAST SURGICAL HISTORY- Please check the box if you have **NOT** had any surgeries

| Type of Surgery | Date |
|-----------------|------|
| | |
| | |
| | |
| | |

NON-SURGICAL HOSPITALIZATIONS- Please check the box if you have **NOT** had any hospitalizations

| Reason | Date |
|--------|------|
| | |
| | |

FAMILY MEDICAL HISTORY- Please check the box if NONE of the following apply

Place an "X" in the appropriate boxes to identify all illnesses/conditions in your **blood relatives**:

| ILLNESS/CONDITION | FAMILY MEMBER | | | | | |
|------------------------------------|---------------|--------|---------|--------|-------------|-------|
| | Mother | Father | Brother | Sister | Grandparent | Other |
| Alcohol/drug abuse | | | | | | |
| Cancer (please list type) | | | | | | |
| Depression/psychiatric illness | | | | | | |
| Diabetes | | | | | | |
| Genetic (inherited) disorder | | | | | | |
| Heart Disease | | | | | | |
| High blood pressure | | | | | | |
| High cholesterol | | | | | | |
| Liver disease | | | | | | |
| Stroke | | | | | | |
| Other (specify) | | | | | | |

Why are we seeing you today? _____

I certify that the above answers are true and correctly recorded and give permission for the examination

Signed: _____

Date: _____

