**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 First Choice of the Midwest, If your primary insurance is KID Chip or Medicaid (Title 19), the state of Wyoming does not cover podiatry services provided by a specialist. If you have Kid Chip or 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 >**

**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

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 _____

Facebook _____

Internet _____

Newspaper _____

Phonebook _____

Billboard _____

Health Fair _____

Radio _____

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

## *PATIENT INFORMATION*

Name_____ Gender: ☐ Male ☐ Female
**Last** **First** **Middle Initial**

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**

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.) |
|---|---|---|---|
| *Example: metoprolol* | *25 mg* | *1 TAB* | *Once daily* |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

***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: _____**