

**GREEN FOOT & ANKLE CARE  
W JOSEPH SCHOEPPNER, DPM  
PATIENT INFORMATION**

Patient Name \_\_\_\_\_ Preferred Name \_\_\_\_\_

Home Phone(\_\_\_\_) \_\_\_\_\_ Work Phone(\_\_\_\_) \_\_\_\_\_ Cell Phone(\_\_\_\_) \_\_\_\_\_

Address \_\_\_\_\_  
STREET CITY STATE ZIP

SSN \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Email Address \_\_\_\_\_

Birth Date \_\_\_\_/\_\_\_\_/\_\_\_\_ Sex: Male Female Marital Status: Married Widowed Single Divorced

Race: White African American Other \_\_\_\_\_ Ethnicity: Hispanic Not Hispanic Primary Language: \_\_\_\_\_

Occupation \_\_\_\_\_

Employer \_\_\_\_\_

Address \_\_\_\_\_  
STREET CITY STATE

Spouse Name \_\_\_\_\_ Birth Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Employer \_\_\_\_\_

SSN \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Work Phone (\_\_\_\_) \_\_\_\_\_ Cell Phone (\_\_\_\_) \_\_\_\_\_

**FILL OUT ONLY IF PATIENT IS A MINOR**

Mother Name \_\_\_\_\_ Father Name \_\_\_\_\_

Birth Date \_\_\_\_/\_\_\_\_/\_\_\_\_ Birth Date \_\_\_\_/\_\_\_\_/\_\_\_\_

SSN \_\_\_\_\_ SSN \_\_\_\_\_

Work Phone (\_\_\_\_) \_\_\_\_\_ Work Phone(\_\_\_\_) \_\_\_\_\_

Cell Phone (\_\_\_\_) \_\_\_\_\_ Cell Phone (\_\_\_\_) \_\_\_\_\_

Employer \_\_\_\_\_ Employer \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Relationship \_\_\_\_\_

Home Phone(\_\_\_\_) \_\_\_\_\_ Work Phone(\_\_\_\_) \_\_\_\_\_ Cell Phone(\_\_\_\_) \_\_\_\_\_

**INSURANCE INFORMATION**

**PLEASE PRESENT YOUR INSURANCE CARD(S) & DRIVER'S LICENSE TO THE RECEPTIONIST TO COPY**

Primary Insurance: \_\_\_\_\_ Secondary Insurance: \_\_\_\_\_

ID #: \_\_\_\_\_ ID #: \_\_\_\_\_

Group #: \_\_\_\_\_ Group #: \_\_\_\_\_

Subscriber Name: \_\_\_\_\_ Subscriber Name: \_\_\_\_\_

Subscriber DOB: \_\_\_\_\_ Subscriber DOB: \_\_\_\_\_

**CONSENT FOR TREATMENT**

**Must be signed by all patients or guardians prior to being seen by physician**

I certify that the information is true and correct to the best of my knowledge. I give my permission to the doctor to examine, photograph, x-ray, administer and perform such procedures as may be deemed necessary in the diagnosis and/or treatment of my foot and/or ankle problems.

\_\_\_\_\_  
Signature of Patient, Parent, Guardian or Personal Representative Relationship Date

## MEDICAL HISTORY

Please fill out all blanks, use N/A if question does not apply

Patient Name \_\_\_\_\_ Birth Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Are you pregnant? \_\_\_\_\_ Shoe Size \_\_\_\_\_ Weight \_\_\_\_\_ Height \_\_\_\_\_

Past Medical History – Please circle those that apply

AIDS/HIV	Cancer	High Blood Pressure	Shortness of Breath
Anemia	Chemical Dependency	History of Chemotherapy	Sinus Problems
Angina	Circulatory Problems	Kidney Problems	Stroke
Arthritis	Diabetes	Liver Disease	Swelling in Ankle/Foot
Artificial Heart Valves/Joints	Epilepsy/Seizures	Mitral Valve Prolapse	Thyroid Disease
Asthma	Fainting	Phlebitis	Transfusions of Blood
Back Problems	GI Ulcer/Bleeding	Pneumonia	Tuberculosis
Bleeding Disorder	Gout	Psychiatric Care	Ulcers
Blood Clots/DVT	Heartburn/Reflux	Respiratory Disease	Varicose Veins
Blood Thinners	Hemophilia	Rheumatic Fever	Weight Loss
Bronchitis	Hepatitis or Jaundice	Sexually Transmitted Disease	

Any other medical conditions not listed here \_\_\_\_\_

Surgical History, please list all surgeries \_\_\_\_\_

Hospitalizations, other than for surgeries \_\_\_\_\_

Any Major Injuries \_\_\_\_\_

**Allergies** – Please circle those that apply

Adhesive/Tape	Demerol	Novocain	Anticoagulant Therapy	Eggs
Iodine	Penicillin	Aspirin	Anti-inflammatory Meds	Peanuts
Seafood	Codeine	Cortisone	Local Anesthetics	Glove Powder
Latex	Sulfa	Morphine	NSAIDS	Other _____

**Current Medications**, include over the counter medications and vitamins (or provide a list to copy)

Do you take oral contraceptives? Yes \_\_\_ No \_\_\_

## PODIATRY HISTORY

Chief Complaint(s) \_\_\_\_\_ Duration of Symptoms \_\_\_\_\_

Have you had previous treatment for this condition? Yes \_\_\_ No \_\_\_ By Whom? \_\_\_\_\_

Do you currently have or have had in the past any of the following - Please circle those that apply:

Ankle Pain	Athlete's Foot	Bunions
Corns/Calluses	Flat Feet	Foot/Leg Cramps
Heel Pain	Ingrown Toenails	Plantar Warts
Tired Feet	Swelling in Legs/Feet	Other _____

Athletic activities in which you participate (please list and indicate frequency) \_\_\_\_\_

Is visit due to an accident? Yes \_\_\_ No \_\_\_ Have you ever seen a Podiatrist before? Yes \_\_\_ No \_\_\_

If yes: Name \_\_\_\_\_ Date of last visit \_\_\_\_\_

Family Doctor \_\_\_\_\_

Phone \_\_\_\_\_ Date Last Seen \_\_\_\_\_

Cardiologist \_\_\_\_\_

Phone \_\_\_\_\_ Date Last Seen \_\_\_\_\_

Endocrinologist \_\_\_\_\_

Phone \_\_\_\_\_ Date Last Seen \_\_\_\_\_

Preferred Pharmacy \_\_\_\_\_ Phone \_\_\_\_\_

Whom may we thank for referring you? \_\_\_\_\_

## **FINANCIAL POLICY**

**Patient or Authorized Representative's Initials Represent that I have read, understand, and accept these policies**

We will help you receive maximum benefits by filing claims for you. We are committed to providing you with the highest quality medical and surgical care. In return, we ask you be equally committed to being fully responsible for paying our fees. This will help in reducing our billing and administrative burdens, leaving more time for helping you. This dual commitment is the foundation of our relationship. Our goal is to maximize the quality of your care and minimize misunderstandings regarding fees and payment. To ensure quality communication, it is the patient's (and/or guardian's) responsibility to inquire about fees/insurance coverage prior to any service being performed. We accept many different insurance plans, however all plans are not the same and do not cover the same services.

**Please note: It is the responsibility of each patient to know his or her contract limitations. Specifically, if your policy requires a written referral prior to your visit. It is the patients responsibility to obtain that referral (or have it sent to our office) prior to making an appointment at Green Foot & Ankle Care.**

### **Managed Care Patients/Private Insurance**

If you are in a managed care plan (HMO, PPO, IPA) with whom we participate, we abide by our contract with them. We will bill your insurance company; however you are responsible for paying any Co-pays, Coinsurance and Deductibles required by your plan at the time of treatment.

### **Medicare Patients**

We accept assignment for Medicare, that does not mean that all services are covered. Patients are responsible for paying their annual deductible. You are also responsible for any co-insurance, which is usually 20% of the allowed amount for an item or service.

### **Uninsured Patients**

A minimum of \$125.00 in the form of cash, check or credit card is due at the time of service. Additional charges may apply.

### **All Patients**

For your convenience, we accept Visa, MasterCard, Discover, Debit, Cash or Check. There is a \$10 service fee for all returned checks.

### **Separate Billing Notice**

Please understand you will receive a statement for services from Green Foot & Ankle Care and if a procedure is performed you may also receive a separate statement from the lab for pathology testing, You also understand if a procedure is performed at an outpatient facility a separate statement will be received from the facility for the facility services.

## **DURABLE MEDICAL EQUIPMENT POLICY**

It is the policy of this office to help obtain insurance benefits regarding a patient's individual coverage of these items. This is a courtesy, which we are happy to provide; however, Green Foot & Ankle Care is not responsible for the accuracy of the information received. Information received by phone is not a guarantee of payment and if any doubt exists as to eligibility, it is highly recommended that you check your plan booklet for a detailed outline of your benefits or make a personal phone call to your insurance company. Please note, if these items are denied by insurance due to coverage limitations, the patient hereby accepts responsibility for the cost.

**Initial** \_\_\_\_\_ **Date** \_\_\_\_\_

**DISCLOSURE AUTHORIZATION  
ALL PATIENTS MUST COMPLETE**

Patient Name \_\_\_\_\_ DOB \_\_\_\_\_

May we leave a message at your home or with other residents? Circle Yes No

May we leave a message on your answering machine/voicemail? Circle Yes No

May we send you an e-mail? Circle Yes No

How would you prefer appointment reminders?

Phone \_\_\_\_\_ E-Mail \_\_\_\_\_

Whom may we discuss your medical/financial information with?

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Home \_\_\_\_\_ Work \_\_\_\_\_ Cell \_\_\_\_\_

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Home \_\_\_\_\_ Work \_\_\_\_\_ Cell \_\_\_\_\_

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Signature of Patient, Parent, Guardian or Personal Representative

Date

