

Account No. _____

Keith R. Reber, D.P.M.
S. Kent Burton, D.P.M.
Lary J. Smith, D.P.M.
Carl Van Gils, D.P.M.



Andrew B. Powell, D.P.M.
Leon K. Reber, D.P.M.
Brad S. Webb, D.P.M.
Ryan T. Peterson, D.P.M.
Shirl C. Cowley, D.P.M.

Patient Name(First) _____ (Initial) _____ (Last) _____

Permanent Mailing Address _____ City _____ State _____ Zip _____

Temporary Mailing Address _____ City _____ State _____ Zip _____

Phone (____) _____ Cell Phone (____) _____ Date of Birth ____/____/____ Age _____

Sex: Male Female E-mail Address _____ Social Security No. _____

Race* _____ Ethnicity* _____ Language* _____ Education* _____

Marital Status*: Single Married Divorced Widow Separated Employment*: full part self retired unemployed

Parent (if Patient is under 18) _____ *=federally mandated info.
Name phone

Patient/Parent Employer _____ Business Phone _____

Name of Spouse _____ Spouse's Employer _____

Primary Care Physician: _____
First Last Month/Year of last visit to PCP If not a local doctor, please list address or phone #

INSURANCE INFORMATION: Is patient covered under Medical Insurance? YES NO
Primary Insurance Secondary Insurance

Ins. Name _____

Policy #: _____

Subscriber Name: _____

Subscriber's Date of Birth ____/____/____

Subscriber's relationship to patient _____

Ins. Name _____

Policy #: _____

Subscriber Name: _____

Subscriber's Date of Birth ____/____/____

Subscriber's relationship to patient _____

Reason for today's visit: _____ Referring Dr. _____

I hereby give Keith R. Reber, DPM, and/or S. Kent Burton, DPM, and/or Lary J. Smith, DPM, and/or Carl C. Van Gils, DPM, and/or Andrew B. Powell DPM, and/or Leon K Reber, DPM, and/or Brad S. Webb, DPM and/or, Ryan T. Peterson, and/or Shirl C. Cowley and/or South Main Surgery Center permission to examine and treat my lower limbs.

I, undersigned patient or guardian, agree to pay the customary charge for all services in full, at the time of services, unless other written arrangements are made with and signed by the staff. In the event that my insurance carrier is billed for service rendered, I authorize payment of medical benefits directly to the Foot and Ankle Institute, and/or the treating doctor(s). In the event that my insurance carrier reduces benefits due to deductible and copayments, or if customary charges are more than those allowed under my insurance plan, I agree to pay the difference within 30 days following notification. Although customary charges will be billed for all services rendered, they may be adjusted at the time of insurance payment according to the agreement Foot & Ankle Institute has with the insurance companies with which it participates. I authorize release of any medical information necessary to process this claim. In the event of default on this agreement, I agree to pay any and all reasonable and customary collection fees, including attorney fees and/or court fees. I agree to pay a \$10 processing fee for copays not paid at the time of service. I understand that interest charges may be assessed at the rate of 1.5 percent per month, before and after judgment, on any past due amount.

(Please Initial) I acknowledge that I was provided a copy of the Notice of Privacy Practices, that I have been provided ample opportunity to read, and I understand and agree with said Notice.

PATIENT'S SIGNATURE _____ DATE _____

PARENT'S OR GUARDIAN'S SIGNATURE _____ DATE _____

PATIENT HISTORY

Are you **allergic** to:

Adhesive Tape	Y	N	Foods	Y	N
Antibiotics	Y	N	Morphine	Y	N
Aspirin	Y	N	Penicillin	Y	N
Chemicals	Y	N	Sulfa Drugs	Y	N
Codeine	Y	N	Other Drugs	Y	N

Has anyone in your family (Mother, father, siblings, grandparents, aunt, uncle, etc) had any of the following?
If so, who?

Arthritis: _____
Birth Defects: _____
Cancer (what kind): _____
Diabetes: _____
Heart Attack: _____
High Blood Pressure: _____
Osteoporosis: _____
Stroke _____

Do you drink alcohol?	Yes	No
Do you smoke?	Yes	No
Do you chew tobacco?	Yes	No
Do you use recreational drugs?	Yes	No

Please list all surgeries you have had along with the approximate dates:

Please list all medications you are presently taking:

Please circle those **YOU** have been treated for:

HEART: Rheumatic Fever, Murmur, Chest Pain, Heart Attack, Angina, Congestive Heart Failure, Hypotension, Hypertension.

SKIN: Lesions, Moles, Eczema, or Rashes.

ENDOCRINE: Diabetes, Hypoglycemia, or Thyroid Dysfunctions.

GASTROINTESTINAL: Ulcers, Hiatal Hernia, Reflux, Diverticulitis, or Diarrhea

BLOOD: Anemia or Bleeding Tendencies.

LIVER: Hepatitis or Liver Dysfunction

MUSCULO-SKELETAL: Serious injuries or disorders of the Back, Deformities, Loss of Strength, Joint Pains or history of Osteoarthritis or Rheumatoid arthritis.

NEUROLOGIC: Weakness, Numbness, Strokes, Seizures, or Migraines.

LUNGS: Asthma, Pneumonia, Shortness of Breath, Emphysema.

KIDNEYS: Kidney, Bladder, or Prostate problems.

What is your foot problem? _____

When did the problem begin? Date: _____

Describe any accident or event: _____

Is this the first visit to a doctor for this problem?
