PODIATRY 1st

JAMES ANDERSON D.P.M.
NATALIE MOTA D.P.M.
JOHN LINDSAY D.P.M.

O'Fallon Office
717 Insight Ave.
Suite 100
O'Fallon, IL 62249

Columbia Office
1000 Eleven South
Suite 3A
Columbia, IL 62236

St. Louis Office
11710 Old Ballas Rd.
#100
St. Louis, MO 63141

Phone : 618-277-9533 | Fax : 618-277-9540

First Name: ______________________________ M.I.: ____ Last Name: ______________________________________

Date of Birth: ______ /______ / ______ Sex: _ Male _Female Preferred Phone: ______________________________

Home Address: ______________________________ City _______________________ State _____ Zip _____________

Email Address: ____

How did you hear about us?

□ Google/Internet Search □ Existing Patient/Friend/Family: ____
(please provide name so we can thank them)

□ Physician Referral: __________________________ □ Other:____

Race/Ethnicity (Optional)

Race: □ Caucasian □ African American □ Asian □ Hispanic □ American Indian □ Other □ Prefer Not to Answer
Ethnicity: □ Hispanic/Latino □ Not Hispanic/Latino □ Prefer Not to Answer
Marital Status: □ Single □ Married □ Divorced □ Widowed

Employment Status: □ Employed FT □ Employed PT □ Unemployed □ Retired □ Disabled

Patient's Employer: ________________________________ Occupation: _____________________________________

Insurance Information

Primary Insurance:____ ID #: ____________________________________

Policy Holder Name: ________________________________ Policy Holder Date of Birth: ________________________

Relationship to Patient:______________________________Insured Person's Phone #: __________________________

Do you have a secondary insurance? YES NO

What is your preferred pharmacy? ____________________________ Phone Number: _________________________

Location: Street:______________________________ City _________________________ Zip_____________________

Who is your family doctor? ___________________________ Location: ______________________________________

Date you last saw your physician: _______ / _______ / _________

Emergency contact information

Name: _________________________________ Relation: _________________ Phone:__________________________

Patient Signature: ____ Date:___________________________

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REQUEST FOR CONFIDENTIAL INFORMATION

I hereby request Podiatry 1st to contact me by: (Please check all that apply)

[ ] Cell Phone May leave message: Yes_____ No_____

[ ] Home Phone May leave message: Yes_____ No_____

[ ] Work Phone May leave message: Yes_____ No_____

I also authorize Podiatry 1st to speak with the following people in regards to my diagnosis and/or treatment options or any other related healthcare issues:

Name:__________________________________ Relationship: _________________Phone: ________________________

Name:__________________________________ Relationship: _________________Phone: ________________________

Name:__________________________________ Relationship: _________________ Phone: ________________________

I understand that Podiatry 1st is not required by law to agree to this request but every attempt will be made to abide by my restrictions unless I am in need of emergency treatment. This agreement is valid until revoked by me in writing.

SIGNATURE: ____ DATE: _________________________________

INSURANCE AUTHORIZATION AND ASSIGNMENT GUARANTY OF PAYMENT OF MEDICAL SERVICES

I hereby authorize Podiatry 1st to furnish information to insurance carriers, other physicians and any other facilities involving the treatment/care of illness/injuries and for services provided as a patient of Podiatry 1st. I also hereby assign to the physician(s) all payments for medical services rendered to myself or my dependents. I authorize payment of benefits to the physician or supplier. I understand that I am financially responsible for all medical and related charges incurred by me and/or my dependent in my/his/her medical treatment provided by my physician or other persons or facilities acting with or in the place of my physician, whether or not such charges are covered by insurance, including any and all collection fees, costs and attorney fees incurred by the physician or facility in collecting my or my dependent's medical bill. This authorization applies to all occasions of service until it is revoked by me in writing. I also hereby authorize photocopies of this authorization form to be as valid as the original.

SIGNATURE: ____ DATE: _________________________________

NOTICE OF PRIVACY PRACTICES / PATIENT RIGHTS AND RESPONSIBILITIES ACKNOWLEDGMENT

I acknowledge that I am aware of Podiatry 1st's Notice of Privacy Practices and consent to the use of disclosure of my Protected Health Information (PHI) by Podiatry 1st for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills, to conduct health care operations of Podiatry 1st and as required by law. I also acknowledge that I was offered the entire notice and that I understand I may obtain a full version of the notice at any time. I understand my rights as a patient of this practice concerning my PHI, as it is outline in this notice and in addition I have received a copy of Podiatry 1st's Patient Rights and Responsibilities. I am aware that Podiatry 1st reserves the right to change the privacy practices that are described in this Notice of Privacy Practices. I may obtain a revised Notice of Privacy Practices by contacting the office.

SIGNATURE: ____ DATE: _________________________________