FOOT CARE CENTER OF GUNTERSVILLE
PATIENT INFORMATION

Name _____ Date ___/___/_____ Date of Birth ___/___/_____
Last First Middle

Address _____ City _____ State _____ Zip _____

Phone # (____) _____-_____ Cell # (____) _____-_____ SS# _____-____-_____ Sex □M □F Age_____ Status □S □D □M □W

By whom were you referred?_____ Main Foot Problem_____

Foot Pain(check all that apply):□Pain in AM □Pain when walking □Pain after being on feet all day □General Foot Pain

Are you in: □Good Health □Fair Health □Poor Health Height___'____" Weight_____ Shoe Size _____

_____
Occupation Employer Address City Phone Number

_____
Emergency Contact Relationship Phone Number Cell Phone Number Employer

_____
Guardian/Responsible Party Relationship SS# DOB Employer

_____
Primary Care Physician's Name Address City Phone Number

Insurance:□BC/BS □Medicare □Other _____

Under a Doctor's Care:□No □Yes, Reason_____

Allergies:□None □Aspirin □Demerol □Iodine □Adhesive Tape □Codeine □Penicillin □Other _____

_____
List on the line above the medications you are currently taking

Have you ever Been Diagnosed with(check next to the ones that apply):□Asthma □Anemia □Cancer □Diabetes □Tumors □Nervousness □Epilepsy □Glaucoma □Gout □Stroke □Liver Disease □Heart Trouble □Bladder Trouble □Kidney Trouble □High Blood Pressure □Ulcers □Arthritis □Bleeding Trouble □Slow Healing □Other _____

I authorize payment of any medical benefits to the physician providing the medical services submitted for payment that would have otherwise been payable to me. I understand that any amount deemed by my insurance carrier to be beyond the "usual, reasonable and/or insurance carrier to be beyond the "usual, reasonable and/or customary" charges for said services will be paid to me. **ATTENTION INSURED**: I understand that some procedures done by the physician and approved by me are not covered by my individual insurance group. I accept the responsibility for the immediate payment of the charges not covered by my insurance company and agree to pay attorney's fee, court costs, and any other reasonable costs of collection should I fail to make payment.

_____**AUTHORIZATION TO RELEASE INFORMATION:** I hereby authorize the physicians of Foot Care Center of Guntersville to release any information acquired in the course of my treatment to my referring or primary care physician for the purposes of apprising the physician of your care or thanking him for the referral.

_____**AUTHORIZATION TO RELEASE INFORMATION:** I hereby authorize the physicians of Foot Care Center of Guntersville to release any information acquired in the course of my examination and treatment to my insurance company. My medical information includes any and all records related to my diagnosis, treatment, and care.

_____**PAYMENT TERMS:** As consideration for the physician's services, I agree to pay all charges for services at the completion of such services. As agreed, the physician may, at his discretion, place the unpaid account with an attorney for collection. If this action is necessary, I agree to pay an attorney's fee, court costs, and any other reasonable cost of collection. **I UNDERSTAND ANY UNPAID BALANCE AFTER 30 DAYS WILL INCUR INTEREST AT THE RATE OF 18%.**

Keep the planet green: Please send all correspondences including bills via e-mail. My e-mail address is:
_____@_____._____

I have read and understand the above statements: **SIGNATURE**_____ **DATE** ___/____/_____