Robert M. Johnson, D.P.M.

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PATIENT INFORMATION SHEETS DATE_______________________

NAME_______________________________________SEX: MALE____FEMALE_____

ADDRESS___________________________CITY____________________ZIP___________

HM#________________________CELL#____________________BIRTHDATE____________

MARITAL STATUS: SINGLE______ MARRIED______ WIDOWED_____ DIVORCED______

LANGUAGE______________RACE__________________ EMAIL__________________________

SOCIAL SECURITY #__________________________REFERRED BY______________________

EMPLOYER____________________________________PHONE#___________________

SPOUSE'S EMPLOYER_____________________________PHONE#___________________

PRIMARY CARE DOCTOR___________________________ LAST VISIT__________________

PERSON RESPONSIBLE FOR ACCOUNT (IF OTHER THAN PATIENT)

NAME____RELATIONSHIP_____________

ADDRESS_____________________________________PHONE#_________________

PRIMARY INSURANCE: ____

INSURED ID#__________________________________GROUP#____________________

INSURED'S NAME_____________________________INSURED'S BIRTHDAY___________

INSURED'S RELATIONSHIP TO PATIENT_______________________________________

SECONDARY INSURANCE____

INSURED ID#__________________________________GROUP#____________________

INSURED'S NAME_____________________________INSURED'S BIRTHDAY___________

MEDICAL INFORMATION (PLEASE COMPLETE IN FULL)

NAME OF PHARMACY_______________________________ADDRESS__________________________________

DESCRIBE YOUR FOOT PROBLEM____

THEY HAVE TROUBLED ME FOR DAYS________ WEEKS________ MONTHS________ YEARS______

SHOE SIZE________________ WEIGHT__________________ HEIGHT__________________

PREVIOUS CARE BY A FOOT SPECIALIST? YES___________ NO__________

NAME OF SPECIALIST____LAST VISIT_____________

MEDICAL HISTORY: CHECK THE FOLLOWING THAT YOU HAVE NOW OR IN THE PAST

______ANEMIA ______FAINTING _____PERIPHERAL VAS DIS (PVD)

______BLEEDING PROBLEMS ______GOUT _____RHEUMATOID ARTHRITIS

______DIABETES ______HEART TROUBLE _____ STOMACH ULCERS

______DIFFICULTY HEALING ______HIGH BLOOD PRESSURE _____OTHER_______________

______EPILEPSY ______OSTEO ARTHRITIS (DJD)

____

MEDICATIONS YOU ARE NOW TAKING:____

____

ARE YOU IN GOOD HEALTH? YES______ NO______

HAVE YOU HAD ANY RECENT OR PAST OPERATIONS? YES_____ NO_____ IF YES, PLEASE LIST:

____

HISTORY OF DIABETES IN YOUR FAMILY? YES______ NO______RELATIONSHIP______________

DO YOU HAVE ANY ALLERGIES? YES_____ NO_____ CIRCLE ANY KNOWN ALLERGIES BELOW:

ASPIRIN CODEINE LOCAL ANESTHETIC SULFA

ADHESIVE TAPE CORTISONE NOVACAINE OTHER ANTIBIOTICS

BARBITUATES DEMEROL PENICILLIN OTHER MEDICATIONS:

____

DO YOU SMOKE? YES_____NO____#OF PACKS PER DAY______________________

PREVIOUSLY SMOKED: YES_____ NO_____NUMBER OF YEARS_____________________

DO YOU DRINK ALCOHOL OR BEER: YES_____ NO_______

IF YES, USAGE: LIGHT, 1-2 PER WEEK______ MODERATE 1-2 PER DAY_____

HEAVY, MORE THAN 2 DAILY______

SIGNATURE_______________________________________DATE_________________________

INSURANCE AND MEDICARE:(PLEASE READ AND SIGN BELOW)

The contract for coverage of the expense for doctor's care is between the patient and the doctor. Your doctor looks to you for payment of any and all bills, and assumes no responsibility for the collection of insurance payments. An insurance policy is a contract between the patient and the insurance company.

It is the responsibility of the patient to know whether his/her insurance carrier provides insurance coverage for the medical services that are provided by Dr. Robert Johnson, DPM.

Particularly if a patient has a managed care plan, some medical services are not necessarily covered benefits to the patient and payment will be denied, which will result in our office billing the patient for these non-covered medical services. Because of the numerous insurance plans that can be offered buy employers, it is difficult for our office to always be able to inform a patient when we are not an in-network provider. This does not relieve the patient of financial responsibility. Our office will bill your medical services with your insurance carrier. It is expected that the patient will pay his/her co-pay, coinsurance and or deductible at the time of service. We do accept Medicare assignment for COVERED services. However, several podiatric services, including routine foot care, may not be covered. We will file an insurance claim for COVERED services.

"I agree to be fully responsible for all lawful debts incurred by myself or my minor child for services received by Robert M Johnson DPM, whether those services are covered by insurance or not."

Patient signature:_______________________________________ Date_________________

or Responsible Party:____________________________________ Date_________________