APPLE HILL PODIATRY ASSOCIATES, P.C.

DEE STELMACH, D.P.M., FACFAS
DAVID F. BASKWILL, D.P.M., FACFAS, FACFO
STACIE S. SMITH, D.P.M., FACFAS

PLEASE PRINT

PATIENT INFORMATION TODAY'S DATE________________

NAME____ MARITAL STATUS: S M W D SEX: M F

ADDRESS____ CITY__________________ STATE______________ ZIP__________

HOME TELEPHONE #________________________________ BIRTHDATE______________________ AGE_________

SOCIAL SECURITY #________________________________ EMPLOYER________________________________ WORK #________________

PATIENT HISTORY

MY MAIN CONCERN WITH MY FEET IS____

____ HAVE YOU HAD PREVIOUS CARE FOR THIS?________

ARE YOU ALLERGIC TO ANY OF THE FOLLOWING: (ANSWER YES OR NO TO ALL)

ASPRIN________________ IODINE_______________ SULFA DRUGS____________ OTHER________________ OTHER________________
ADHESIVE TAPE__________ PENICILLIN____________ NOVACAINE______________ OTHER________________ OTHER________________

DO YOU HAVE, OR HAVE YOU EVER HAD, ANY OF THE FOLLOWING: (ANSWER YES OR NO TO ALL)

DIABETES_______________ HEART TROUBLE__________________ ASTHMA____________________________ THYROID DISORDERS________________
ARTHRITIS______________ KIDNEY DISEASE__________________ HIGH BLOOD PRESSURE______________ OTHER____________________________
EPILEPSY_______________ BLADDER TROUBLE________________ AIDS OR HIV +______________________ OTHER____________________________
BLOOD CLOTS____________ STOMACH TROUBLE_______________ CLOTTING DISORDERS_______________ OTHER____________________________

PLEASE LIST ALL SURGERY THAT YOU HAVE HAD:

TYPE OF SURGERY	DATE OF SURGERY
1.________________________________	____________________
2.________________________________	____________________
3.________________________________	____________________
4.________________________________	____________________

PLEASE LIST ANY RECENT HOSPITALIZATIONS:

1.________________________________ ____________________
2.________________________________ ____________________

PLEASE LIST ALL MEDICATIONS THAT YOU ARE CURRENTLY TAKING;

1.________________________ 2.________________________ 3.________________________
4.________________________ 5.________________________ 6.________________________

WHO IS YOUR FAMILY PHYSICIAN? (NAME)_________________________________(Phone #)_______________

ADDRESS____

WHO MAY WE CONTACT IN CASE OF AN EMERGENCY________________________________ PHONE #____________

WERE YOU REFERRED TO US BY A PHYSICIAN? __________ Physician's Name:___________________________

WHO ELSE MAY WE THANK FOR REFERRING YOU TO OUR OFFICES? _____________________________________

I hereby give permission to Apple Hill Podiatry Associates, P.C. to examine and treat my feet medically, surgically or orthopedically and to administer treatment. I also give permission for them to perform such minor operative procedures as may be necessary in the diagnosis and treatment of my condition.

PATIENT OR AUTHORIZED SIGNATURE TODAY'S DATE

AUTHORIZATION TO RELEASE INFORMATION & ASSIGNMENT OF BENEFITS

I hereby authorize the release of any information necessary to process any claims for services provided to me by

Apple Hill Podiatry Associates, P.C. I request payment of this claim and, if the payor accepts assignment, authorize payment to be made directly to the physician or supplier for the services rendered.

PATIENT OR AUTHORIZED SIGNATURE ______________________ TODAY'S DATE ______________

INSURANCE INFORMATION

PRIMARY INSURANCE

Policy Subscriber:

NAME______________________ MARITAL STATUS: S M W D SEX: M F

ADDRESS______________________ CITY______________ STATE__________ ZIP________

HOME TELEPHONE #______________________ BIRTHDATE______________ AGE________

INSURANCE I.D. #______________________ EMPLOYER______________ WORK #________

EMPLOYER ADDRESS ____

SUBSCRIBER EMPLOYMENT STATUS:

STUDENT____________ FULL TIME EMPLOYED____________ NOT EMPLOYED____________

PART TIME EMPLOYED____________ SELF EMPLOYED____________ RETIRED____________

IS THE POLICY SUBSCRIBER: PATIENT__________ SPOUSE __________ PARENT/GUARDIAN __________OTHER __________

INSURANCE COMPANY NAME____

ADDRESS______________________________ TELEPHONE #______________

GROUP NUMBER______________________ INSURED ID# or POLICY NO.______________________

Do you have a COPAY (yes/no)? ______________ COPAY Office Visit Amount? ______________

Do you have a DEDUCTIBLE (yes/no)? ______________ DEDUCTIBLE Amount? ______________

Do you have a COINSURANCE % PAYMENT (yes/no)? ______________ COINSURANCE % ______________

SECONDARY/OTHER INSURANCE

Policy Subscriber:

NAME______________________ MARITAL STATUS: S M W D SEX: M F

ADDRESS______________________ CITY______________ STATE__________ ZIP________

HOME TELEPHONE #______________________ BIRTHDATE______________ AGE________

INSURANCE I.D. #______________________ EMPLOYER______________ WORK #________

EMPLOYER ADDRESS ____

SUBSCRIBER EMPLOYMENT STATUS:

STUDENT____________ FULL TIME EMPLOYED____________ NOT EMPLOYED____________

PART TIME EMPLOYED____________ SELF EMPLOYED____________ RETIRED____________

IS THE POLICY SUBSCRIBER: PATIENT__________ SPOUSE __________ PARENT/GUARDIAN __________OTHER __________

INSURANCE COMPANY NAME____

ADDRESS______________________________ TELEPHONE #______________

GROUP NUMBER______________________ INSURED ID# or POLICY NO.______________________

Do you have a COPAY (yes/no)? ______________ COPAY Office Visit Amount? ______________

Do you have a DEDUCTIBLE (yes/no)? ______________ DEDUCTIBLE Amount? ______________

Do you have a COINSURANCE % PAYMENT (yes/no)? ______________ COINSURANCE % ______________