CENTRAL OHIO COMPREHENSIVE FOOT CARE, LLC
DELAWARE PODIATRY, LLC

Thank you for choosing Central Ohio Comprehensive Foot Care/Delaware Podiatry! We hope that you find our office warm and welcoming. Our podiatrists are Dr. Gregory Stockfish, Dr. John Slomsky, and Dr. Bryan Feldner whom are all board certified podiatrist.

WHAT IS A PODIATRIST

A podiatrist is a Doctor of Podiatric Medicine (DPM). A podiatrist has specialized training to treat disorders of the foot and ankle, which include bones, tendons and all areas of the foot/ankle. They must complete the following education:

Four years of undergraduate
Four years at an accredited podiatric medical school
Three to four years of only foot and ankle surgical residency training

A podiatrist can treat only foot and ankle conditions, with a few exceptions in some remote areas. Podiatrist are able to treat disorders conservatively as well as surgically. While some podiatrist only treat conservatively our doctors are well trained surgically if all other treatments options have failed. Below are just a few of the disorders that they treat.

- × Ankle Fractures/Ankle Sprains
- × Bunions
- × Hammertoes
- × Diabetic Foot Care
- × Cyst
- × Foot Fractures
- × Plantar Fasciitis
- × Warts
- × Ingrowns
- × Diabetic Ulcers

If you ever have any question about if we treat a problem that you may be having feel free to call us anytime.

Once again we welcome you to our office and are here to help with all of your foot/ankle footcare needs.

Dr. Gregory Stockfish Dr. John Slomsky Dr. Bryan Feldner

☺Welcome to our Office☺
(TO BE UPDATED YEARLY OR WITH ANY INFORMATION CHANGES)

PATIENT INFORMATION

Patient Name: _____ Today's Date: _____
Patient's S.S. #: _____ Date of Birth: _____ Age: _____
SEX: M __ F ___ Marital Status: S __ M __ D __ W __ Race: _____ Language: _____
Street Address: _____ Apt. No.: _____
PO Box: _____ City: _____ State _____ Zip Code+4 Digit: _____
Home phone: (_____) _____ Cell number: (_____) _____
Email Address: _____
Preferred form of contact (circle one): E-mail Cell Phone Home Phone Work Phone
Occupation: _____ Work phone: (_____) _____
Emergency Contact: _____ Emergency Contact Ph: (_____) _____
Is this a work related injury? Yes No If yes you would like us to bill Worker's Comp then we will need the following information:
Date of injury: _____ Claim #: _____
Responsible Party's Contact/Billing information:
Billing Name & Address: _____
_____
Representative Name: _____ Phone #: _____ Fax #: _____

GUARANTOR / PARENT INFORMATION

Responsible Party Name: _____
Relationship to Patient: _____ Responsible Party Date of Birth: _____
Guarantor's Social Security Number: _____ - _____ - _____
Guarantor's Address: _____ Apt. No.: _____
City: _____ State _____ Zip Code: _____
Home phone: (_____) _____ Cell/Pager number: (_____) _____
Employer's Name: _____ Work Phone: (_____) _____

How did you hear about our office?

___Doctor: _____ (First and Last name please)
___Internet
___Friend/Family
___Close to home/work
____Phonebook
____Office Staff
____ Advertisement
____Insurance
____Hospital: _____
____ Other _____

PATIENT's INSURANCE INFORMATION *Please *provide Insurance Card and Photo ID to Receptionist*

Primary Insurance Company's Name: _____
Name of Policy Holder: _____ Date of Birth: _____/_____/_____
SS#: _____-____-_____ Insurance ID Number: _____ Group Number: _____
Secondary Insurance Company's Name: _____
Name of Policy Holder: _____ Date of Birth: _____/____/_____
SS#: _____-____-_____ Insurance ID Number: _____ Group Number: _____

REASON for VISIT

Please list your present foot or ankle concerns, problems or symptoms: _____

_____

MEDICAL HISTORY

When was your last physical exam? _____
Primary/ Family Doctor (*First and Last*): _____
Pharmacy Name: _____ **Location:** _____
May we import your medications from the pharmacy? **Yes** **No**

Height: _____ Weight: _____ **Shoe Size:** _____

Are you currently under medical treatment? .....Yes No
Please describe: _____

_____

Have you ever had any serious illnesses? Yes No

_____

Have you had any operations? .....Yes No
Please describe: _____

_____

Please list your medications you are taking: _____

_____

_____

Do you have a living will or Durable Power of Attorney? Yes No
Do you smoke?..... Yes No
(If yes) _____ # of years _____ # packs per day
Previously Smoked Yes No
Do you use alcohol? ..... Yes No
Do you use illicit drugs? ..... Yes No

Have you had any allergic reactions to the following:

Local Anesthetics (e.g. Novacaine)	Yes	No
Penicillin	Yes	No
Antibiotic _____	Yes	No
Sulfa Drugs	Yes	No
Barbiturates	Yes	No
Sedatives	Yes	No
Aspirin	Yes	No
Latex	Yes	No
Other	Yes	No

Please describe: _____

_____

Women Only:
Have you ever been pregnant? Yes No
If yes, how many pregnancies? _____

Check any of the following you have or had a problem with:

- o Anemia
- o Arthritis
- o Asthma
- o Back Problem
- o Bleeding Tendency
- o Blood Clots
- o Cancer
- o Chicken Pox
- o Circulation
- o Congenital Heart Lesions
- o Diabetes
- o Emotional / Psychiatric Disorder
- o Frequent Infections
- o Glaucoma
- o Gout
- o Healing
- o Heart Disease
- o Heart Murmur
- o High Blood Pressure
- o Infectious Disease (Hepatitis, MRSA,HIV,TB, etc.)
- o Low Blood Pressure
- o Kidney Disease
- o Liver
- o Measles
- o Migraines
- o Mitral Valve Prolapse
- o Mumps
- o Neurological Disorder
- o Pacemaker
- o Respiratory Disease
- o Rheumatic Fever
- o Scarlet Fever
- o Shortness of Breath
- o Skin Rash
- o Sleep Apnea
- o Stroke
- o Thyroid
- o Stomach Ulcers
- o Other:

_____

Family (blood relative) History:

Cancer _____

Diabetes _____

Heart Disease _____

Name: _____ **DOB:** _____ **Date:** _____

Patient Consent for Use and Disclosure of Protected Health Information

With my consent, Central Ohio Comprehensive Foot Care and/or Delaware Podiatry Center may use and disclose **Protected Health Information (PHI)** about me to carry out **Treatment, Payment and Healthcare Operations (TPO).** *Notice of Privacy Practices are available for more complete description of such uses and disclosures at your request.* With my consent, Central Ohio Comprehensive Foot Care may call or send information as indicated below to carry out TPO, such as appointment reminders, insurance items pertaining to my clinical care, including laboratory results among others.

With my consent Central Ohio Comprehensive Foot Care may:

Call me at my home?	___ Yes	___ No	
May we leave a message on a machine at home?	___ Yes	___ No	
Call me at work?	___ Yes	___ No	____Retired
May we leave message on voice mail at work?	___ Yes	___ No	____Retired

With my consent, Central Ohio Comprehensive Foot Care may give appointment information, account information, results of test and/or surgery to family members listed below:

Name: **Relationship:**

1) _____

2) _____

By signing this form, I am consenting to Central Ohio Comprehensive Foot Care's use and disclosure of my PHI to carry out TPO and confirming that I have read the office policies. I also have received/reviewed a copy of the financial policy.

Print Patient Name: _____ **Date:** _____

Signature of Patient or Legal Guardian: _____

IMPORTANT OFFICE POLICIES

MEDICAL INFORMATION

I authorize *Central Ohio Comprehensive Foot Care, LLC/ Delaware Podiatry Center, LLC. to release the medical records concerning my son/daughter/self to any physician, hospital, or agency involved in the care of the patient listed.

ASSIGNMENT OF MEDICAL BENEFITS

I authorize my insurance carrier to assign all surgical and or medical benefits, if applicable, to the appropriate physician. I also authorize release of medical information necessary to process all medical insurance claims. It is your responsibility to inform the office of any insurance changes. In the event you do not do so you will be responsible for all charges incurred. *Knowingly providing insurance information that is expired/terminated is considered insurance fraud. Please make sure we have correct current insurance information.*

PAYMENT POLICY

Co-payments are to be collected at the time services are received. We accept cash, checks, Visa and MasterCard. All medical services provided are directly charged to the patient or responsible party. If our physician is contracted with your insurance carrier, we will accept their negotiated rate for the charges billed. However, you will be responsible for any balance deemed patient responsibility/non-payable/non-covered by your insurance and billed accordingly. Payment is expected in full upon receipt of statement or payment arrangements must be made with our billing office. There is a **service fee of $25.00 for all returned checks**. This is not payable by your insurance company.

CANCELLATION POLICY

Our office requests that if an appointment needs to be cancelled that we receive notice no later than 4 hours prior to the appointment. We reserve the right to charge $25.00 for a "no show" appointment, to be collected on or before your next appointment.

REFERRAL POLICY

I understand that it is my responsibility to obtain a referral through my primary care physician's office if required by my insurance company. Failure to do so will result in charges being billed directly to myself.

I HAVE READ, UNDERSTAND, AND AGREE TO ABIDE BY THE ABOVE RELEASE OF MEDICAL INFORMATION, PAYMENT, AND OTHER OFFICE POLICIES.

Please Read and Sign:

I hereby authorize my insurance benefits to be paid directly to ***Comprehensive Foot Care/Delaware Podiatry Center**. I understand and am responsible for all charges including my added costs incurred due any effort to collect for services rendered. I realize I am responsible to pay for non-covered services and I hereby authorize the release of pertinent medical information to insurance carriers.

Print Name: _____

Signature of Responsible Party: _____ **Date:** _____

*** Central Ohio Comprehensive Foot Care, LLC and Delaware Podiatry Center, LLC are separate entities.**

Revised
1/2014