Midland Podiatry Associates

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Diplomates, American Board of Podiatric Surgery
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4911 Hedgewood Drive
Midland, Michigan 48640
(989) 631-8200
(989) 631-5901

Dear Valued Patient,

You are scheduled for an appointment with one of our physicians soon. Whether you are a new patient or an established patient, it is necessary for us to update all records regularly.

Please fill out and sign the enclosed Patient Information Form and Patient History Form and read and sign our Financial Policy. Please bring the completed forms with you to your appointment.

Please arrive at least 15 minutes prior to your scheduled appointment time to allow us time to register your information. Failure to arrive on time may result in canceling your appointment.

Please bring your insurance cards and a photo identification to all appointments.

Sincerely,

Midland Podiatry Associates, PLLC

Todd E. Laughner, DPM
Eric R. Gaughan, DPM
Christopher M. Gill, DPM

PATIENT INFORMATION FORM

Patient's Full Legal Name: ____ Age: ________

If Minor, Parent or Guardian Name: ___________________________ Relationship: _______________

Address: _________________________________ City: ____________ State: ____ Zip: _________

Phone (circle type: mobile/home/work): ____

Alternative Phone (circle type: mobile/home/work): ____

Email Address: ____

Date of Birth: __________ Gender: ____ Marital Status: __________ Spouses Name: _______________

Race (circle): Hispanic or Non Hispanic Employer: ______________________________________

Primary Care Provider: ____

Date last seen by Primary Care Provider: ____

Preferred Pharmacy: ____

How were you referred to our office? ____

INSURANCE INFORMATION:

Please bring your insurance cards and a photo I.D. to all visits.

Person Financially Responsible: _________________________ Relationship: ______________________

Primary Insurance: _________________________________ Policy Number: _____________________

Group Number: __________ Specialist Co-Pay Amount: ____________

Secondary Insurance: _____________________________ Policy Number: _______________________

Group Number: _______________

If the Policyholder is other than the Patient, please complete the following:

Policyholder's Name: ____ Date of Birth: ____________

Relationship to the Patient: ____

Authorization to Release Medical Information and Assignment of Benefits: I authorize Midland Podiatry Associates, PLLC and all their physicians to furnish my insurance company and/or other providers information which may be requested concerning my health. I also assign the claim payments to be made payable to Midland Podiatry Associates, PLLC: Dr. Todd E. Laughner, Dr. Eric R. Gaughan, Dr. Christopher M. Gill.

Signature of Patient / Responsible Party: ___________________________________ Date: ________

Patient Medical History

Patient Name: ____ Date: __________________________

Height: _________ Weight: _________ Shoe size: _________

Describe the main problem you are having with your feet or ankles that brings you in today _______________

____

Onset of issues/condition ____

Was it the result of an injury? _________ If so, approximate date of injury _____________________________

Location (circle): Left Right Both

Type of Pain (circle): burning cramping dull ache sharp stabbing shooting throbbing tearing

numbness other: ____

When Painful (circle): upon standing while walking after walking during sports with shoes without shoes

worse in A.M. worse in P.M. constant pain other: ____

Have you had foot care for this or any other foot problem before? Yes No

If yes, when and from whom did you receive care? ____

MEDICATIONS: (Attach an additional sheet if necessary)

Drug Name	Dose	Frequency
____________________	_______________	____
____________________	_______________	____
____________________	_______________	____
____________________	_______________	____
____________________	_______________	____
____________________	_______________	____
____________________	_______________	____
____________________	_______________	____

Do you give permission for your physician at Midland Podiatry Associates to review your medication history with your pharmacies or your other health care professionals? Yes No

ALLERGIES:

Do you have any drug, food, contact, or environmental allergies? If so, please list them: __________________

____

MEDICAL HISTORY:

Please circle any of the following conditions that you have now or had in the past:

Diabetes	Arthritis	Cancer	Neuropathy	Heart Problems	Fibromyalgia
Tumors	Ulcers	Skin Disorders	Tuberculosis	Epilepsy	Osteoporosis
Bleeding Problems		Poor Circulation	Hepatitis B	HIV/Aides	Hypertension
High Cholesterol		Gout	Other: ______________________________________		

A1C: ___________________________________ (last number and date)

Date of Last Eye Exam: ____________________ Date of last colonoscopy: ___________________________

Date of most recent flu vaccine: ______________ Date of pneumococcal vaccination: _________________

SURGICAL HISTORY:

Please list all previous surgeries: (attach additional sheet if necessary)

Procedure	Date
____	________________________________
____	________________________________
____	________________________________
____	________________________________

FAMILY HISTORY:

List family members with the following conditions: include type and relation:

Arthritis: ______________________________ Cancer: ____________________________________

Diabetes: ______________________________ Gout: ______________________________________

SOCIAL HISTORY:

(Please circle response)

Level of physical Activity:	None	Occasional	Weekly	Daily	Competitive
Tobacco Use:	Never	Occasional	Former Smoker		Current daily smoker
Alcohol Consumption:	Never	Occasional	Daily: drinks per day ______________		
Drug Use:	Never	Occasional	Daily		

Which of the following are included in your diet?

Grains and starches:	a lot	some	few
Vegetables:	a lot	some	few
Dairy:	a lot	some	few
Meat:	a lot	some	few
Sweets:	a lot	some	few

REVIEW OF SYSTEMS:

If you are experiencing any of the following, please circle:

General: Chills, fatigue, weight gain, weight loss.

Skin (Dermatologic): Brittle nails, bruising, change in wart/mole, ingrown nail, itching, nail changes, nail discoloration, nail thickening, new lesion, painful nail, rash, skin color change, ulcer.

Respiratory: Cough, breathing problems.

Cardiovascular: Chest pain, claudication (cramping in the lower leg due to poor circulation), edema, hypertension, cold extremities.

Musculoskeletal: ankle pain, foot pain, heel pain, back pain, calf pain, knee pain, joint pain, joint stiffness, joint swelling, muscle weakness.

Neurologic: Numbness, tingling, weakness, stroke, tremor, trouble walking.

Hematologic / Lymphatic: Abnormal bleeding, blood clots, easy bruising, slow wound healing, recurrent infection, prolonged infection.

_____ I am not experiencing any of the above conditions.

Signature: ____ Date: ______________________

Midland Podiatry Associates, PLLC Financial Policy

Midland Podiatry Associates, PLLC Financial Policy

Thank you for choosing our office to provide you and your family podiatric care. We are dedicated to providing you with the best possible care and service. We regard your understanding of our financial policies as an essential element of your care and treatment. If you have any questions regarding our financial policy, please feel free to discuss them with our billing department or office managers.

- You are required to obtain all authorizations/referrals for treatment in this office as your insurance requires.
- Unless arrangements have been made in advance by you or your health insurance carrier, payment for office services are due at the time of service, including copay, balances, or deposits. We accept cash, check, Visa, MasterCard, Discover, and American Express.
- You must inform our office of any changes to your insurance, referrals, or authorizations requirements prior to services. In the event the office is not informed, you will be responsible for any charges denied.
- Not all insurance policies and contracts are the same. It is important you contact your insurance company to determine and understand what your policy allows for treatment and services within our podiatric office. We do not know the contract terms for each policy and carrier.
- Your insurance policy is a contract with you and your insurance company. As a courtesy, we will file your insurance claim on your behalf for all insurances we are contracted with. You will be responsible for any balances for services deemed by your insurance company. If you choose to have services that are not covered by your insurance, you will be financially responsible for those services and/or treatments.
- There are certain elective surgical procedures for which we will require prepayment. You will be informed of the fees in advance. The pre-payment is due one week prior to surgery. In the event your insurance company pays in full, you will be issued a refund check within two weeks of us receiving the payment from your insurance.

Cancellation Policy: Please allow at least 24-hour notice for all cancelled appointments. If a 24-hour notice is NOT provided, you will be subject to a $25 cancellation fee.

No Insurance: If you have no insurance, payment is expected at the time of services.

Our financial agreement is with you, our patient, and not your insurance company. Ultimately, you are responsible for your bill. **I have read and understand the financial policies of Midland Podiatry Associates, PLLC and agree to be bound by its terms.**

Signature:____ Date: ______________

Patient or Responsible Party of minor child

Acknowledgment of receipt of Notice of Privacy Practice and Consent to use PHI (Personal Health Information).

The undersigned patient or legal representative of the patient acknowledges that he or she has personally received a copy of the Midland Podiatry Associates Notice of Privacy Policies on the date indicated below.

The Undersigned patient or legal representative of the patient hereby authorizes Midland Podiatry Associates to use or disclose the Patient's PHI to carry out treatment, payment, or Health Care Operations on behalf of the patient.

Signature: ____ Date: ______________

Patient or legal representative