ABC PODIATRY

Always Better Care

Total Foot and Ankle Care

Stuart R. Schilling, D.P.M. Inc. d.b.a.

Dr. Scott R. Littrell
Dr. Richard A. Schilling

Medical & Surgical Foot/Ankle Specialist
Board Certified in Ambulatory Foot Surgery

APPT:_____

LAST NAME _____ FIRST NAME_____ MI_____

DATE OF BIRTH _____ SOCIAL SECURITY NUMBER_____

SINGLE ____ MARRIED ____ WIDOWED ____ DIVORCED ____ EMAIL_____

STREET ADDRESS_____

CITY_____ STATE_____ ZIP_____

HOME PHONE_____ CELL PHONE_____

EMPLOYER _____ WORK PHONE_____

INSURANCE COMPANY(S)_____

EMERGENCY CONTACT _____ PHONE_____

BRIEFLY DESCRIBE YOUR FOOT PROBLEM_____

_____

FORMER FOOT DOCTOR _____ LAST VISIT_____

PRIMARY CARE PHYSICIAN _____ LAST VISIT_____

HOW DID YOU HEAR ABOUT OUR OFFICE?_____

1. ANY DRUG ALLERGIES? ____YES ____NO LIST:_____
2. ARE YOU SUBJECT TO PROLONGED BLEEDING? _____YES _____NO
3. (a) ARE YOU DIABETIC? ____YES ____NO (b) FAMILY HISTORY OF DIABETES? ____YES ____NO
4. HAVE YOU BEEN TREATED FOR THE FOLLOWING: _____SLEEP APNEA

   _____DIABETES _____HIGH BP _____HIGH CHOLESTEROL _____HEART DISEASE _____ASTHMA

   _____EPILEPSY _____LIVER PROBLEMS _____KIDNEY PROBLEMS _____LUNG PROBLEMS _____CANCER

   OTHER _____
5. HAVE YOU BEEN TESTED POSITIVE FOR HEPATITIS OR HIV VIRUS? _____YES _____NO
6. (a) DO YOU SMOKE? ____YES ____NO (b) IF YES, HOW MANY PER DAY? _____
7. (a) HEIGHT _____ (b) WEIGHT _____
8. **WOMEN ONLY**: ARE YOU, OR MIGHT YOU BE, PREGNANT? ____YES ____NO

I HEREBY GIVE MY PERMISSION TO ABC PODIATRY TO ADMINISTER TREATMENT, AND TO PERFORM SUCH MINOR OPERATIVE PROCEDURES AS MAY BE DEEMED NECESSARY IN THE DIAGNOSIS AND/OR TREATMENT OF MY FOOT CONDITION.

ALL MEDICAL RECORDS AND X-RAYS ARE THE PROPERTY OF STUART R. SCHILLING, D.P.M. INC. COPIES OF SAME ARE AVAILABLE UPON WRITTEN REQUEST.

_____ _____

SIGNATURE DATE

Please bring insurance card and ID

5969 East Broad St. Suite 407, Columbus, Ohio 43213 | Ph. 614-755-2290 | Fx. 614-755-6390 | www.abcpodiatry.com

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PATIENT RESPONSIBILITY

To enable us to provide you the best foot care possible, ABC means "Always Better Care."

We need your help:

- Notify us of any changes in your general health / medical history.
- Notify us of any change in your regular medicines.
- Inform any staff member if you're, "Just not feeling well."
- Notify us of any recent, or scheduled, surgery, or tests, by any other doctor.
- Please keep all scheduled appointments. If you are unable to keep your appointment, give our office 24 to 48 hours notice to reschedule for the next appointment time.
- Take/use all medicines as prescribed. If you have a problem with any dispensed or prescribed medicines, notify a staff member as soon as possible.
- Follow home care instructions. The doctors and staff will be happy to review and discuss all home care.
- Inform the office secretary of any changes in your address, phone number or insurance coverage.

With your help, and cooperation, you can be assured of excellent podiatry care.

I have read and understand my "Patient Responsibility" at ABC Podiatry.

_____ _____
Patient Name (please print) Date

_____
Parent or Authorized Representative (if applicable)

_____
Signature

_____
Witness

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PERMIT PAYMENT OF INSURANCE BENEFITS TO PROVIDER

I certify that the information given by me in applying for payment is correct.

I authorize any holder of medical, or other information, about me to release to my insurance carrier any information needed for this, or related, medical or surgical claim.

I request that payment of authorized benefits by made on my behalf. I assign the benefits payable for covered services to the physician, or organization furnishing the services, or authorize such physician, or organization, to submit a claim to my insurance carrier for payment to me.

I request that payment under my medical insurance program be made to ***"Stuart R. Schilling, D.P.M., Inc. d.b.a. ABC Podiatry"*** on any bills for services furnished me by any of the doctors at ABC Podiatry.

FINANCIAL RESPONSIBILITY

I understand that Dr. Schilling's / Dr. Littrell's / Dr. Holland's services and fees for same, are covered under most insurance policies. It has been made clear to me that the Doctor will submit his fees for services rendered to my insurance, on my behalf. I further understand that I am personally responsible for any deductible, co-insurance, and/or portions of this bill not paid by my insurance provider. I understand that I may not be billed until after the insurance claims have been settled.

_____ _____
Patient Name (please print) Date

_____
Parent or Authorized Representative (if applicable)

_____
Signature

_____
Witness

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ACKNOWLEDGMENT OF RECEIPT

OF

"NOTICE OF PRIVACY PRACTICES"

I acknowledge that I was provided a copy of the "Notice of Privacy Practices" and that I have read (or had the opportunity to read, if I so chose) and understood the Notice.

Patient Name (please print) _____ Date _____

Parent or Authorized Representative (if applicable) _____

Signature _____

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PATIENT NAME:			DATE OF BIRTH:
MEDICAL ALLERGIES:			
NAME OF MEDICATIONS:	DOSAGE:	FREQUENCY:	

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