



Bruce W. Krell, DPM

Podiatric Medicine and Surgery
Diplomate, American Board of Podiatric Surgery

PATIENT DEMOGRAPHIC INFORMATION

Date _____

Patient's Name (Last, First, MI) _____

Birth Date _____ Male Female Age _____

Social Security Number _____ - _____ - _____ Marital Status: S M D W Other _____

Local Address (Street. No PO Box) _____

City _____ State _____ Zip Code _____ Local Phone _____

Cell Phone _____ Email address _____

Permanent Address (Street, City, State, Zip) _____

Perm Phone _____ Employer _____ Work Phone _____

Extension _____ Position _____ Primary Insurance Co _____

If the patient is a minor (under 18 years old), who has the legal right to make medical decisions for that minor?

Name(s), Address, Phone Number _____

Policy Holder's DOB _____ Social Security Number _____ - _____ - _____

Relationship To Policy Holder: Self Spouse Child Other Explain relationship _____

Responsible Party's Address (Street. No PO Box) _____

Spouse's Name _____ Spouse's Employer _____

How Were You Referred to Dr. Krell's Office? _____

Who is your PCP? _____ Phone/Fax _____

List All Your Physicians _____

NOTICE

I HEREBY ACKNOWLEDGE THE RECEIPT OF THE NOTICE OF PRIVACY FOR THE OFFICE OF DR. KRELL. I AUTHORIZE THE RELEASE OF ALL MEDICAL INFORMATION NECESSARY TO PROCESS MY INSURANCE CLAIMS AND IS PERTINENT TO MY MEDICAL CARE. I ASSIGN ALL MAJOR MEDICAL AND/OR SURGICAL INSURANCE BENEFITS TO WHICH ENTITLED, INCLUDING PRIVATE INSURANCE, MEDICARE AND ANY OTHER HEALTH PLAN OR INSURANCE BENEFITS TO THE PROVIDER INDICATED ABOVE. I UNDERSTAND I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT PAID BY MY INSURANCE COMPANY, UNLESS ASSIGNEE HAS EXECUTED AN AGREEMENT WITH MY INSURANCE PROVIDER OR PLAN. I UNDERSTAND THAT IF SUCH AN AGREEMENT HAS BEEN EXECUTED, I AM RESPONSIBLE TO PAY ANY DEDUCTIBLE AND/OR COPAYMENT REQUIRED UNDER THE TERMS OF MY INSURANCE PLAN. PAST DUE ACCOUNTS OVER 90 DAYS FROM THE DATE OF SERVICE ARE SUBJECT TO INTEREST CHARGES OF 1.5% PER MONTH. IN THE UNFORTUNATE EVENT THAT AN ACCOUNT IS GIVEN TO A COLLECTION AGENCY OR TO AN ATTORNEY FOR COLLECTION, THEN THE PATIENT/RESPONSIBLE PARTY SHALL PAY ALL COSTS OF COLLECTION INCLUDING REASONABLE ATTORNEY'S FEES AND COURT COSTS, IN ADDITION TO OTHER AMOUNTS DUE. A PHOTOCOPY OF THIS ASSIGNMENT/AUTHORIZATION IS TO BE CONSIDERED AS VALID AS AN ORIGINAL. I UNDERSTAND THAT FAILURE TO GIVE 24-HOUR NOTICE OF CANCELLATION OF APPOINTMENTS MAY RESULT IN AN ADDITIONAL CHARGE TO MY ACCOUNT. I AUTHORIZE FOOT, ANKLE AND LEG PHOTOGRAPHS AND VIDEO TAPE TO BE TAKEN OF ME FOR MEDICAL RECORDS AND INSURANCE CLAIM PURPOSES.

PATIENT/RESPONSIBLE PARTY _____ DATE _____



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PATIENT HISTORY

PATIENT NAME _____ DATE _____

EXPLAIN YOUR COMPLAINT _____

WHEN DID IT START? _____ LEFT/RIGHT/BOTH? _____

WAS THERE AN INJURY? yes no WHEN DID INJURY OCCUR? _____

WHERE DID INJURY OCCUR? _____ IF WORK RELATED, WAS IT REPORTED? yes no

HAVE YOU TREATED THIS CONDITION YOURSELF? yes no HOW? _____

HAVE YOU SEEN ANOTHER DOCTOR FOR THIS PROBLEM? yes no WHO? WHEN? _____

DO YOU WEAR CUSTOM ORTHOTICS NOW? yes no

HAVE YOU WORN CUSTOM ORTHOTICS IN THE PAST? yes no

LIST ALL MEDICATIONS, VITAMINS, OTC PILLS, HERBS AND REMEDIES YOU USE _____

LIST ALL ADVERSE REACTIONS AND ALLERGIES TO ALL MEDICATIONS, PILLS, INJECTABLES, TOPICALS AND TAPE _____

DO YOU NOW HAVE, OR HAVE YOU HAD ANY OF THE FOLLOWING (CHECK NEXT TO EACH):

- ALCOHOL ABUSE ARTERIAL BYPASS OF THE ABDOMEN OR LEG ARTHRITIS BLOOD CLOT TO LEG
- CANCER CHEMOTHERAPY TREATMENT DIABETES DEPRESSION DRUG ABUSE GOUT
- HEART DISEASE HYPERTENSION HIV/AIDS HEPATITIS INFECTIONS
- REFLEX SYMPATHETIC DYSTROPHY SYNDROME/COMPLEX REGIONAL PAIN SYNDROME KIDNEY DISEASE
- LIVER DISEASE LUNG DISEASE MITRAL VALVE PROLAPS NEUROPATHY/NUMBNESS
- PERIPHERAL VASCULAR DISEASE PSYCHIATRIC DISORDER REPLACEMENT OF HIP, KNEE OR SHOULDER JOINTS
- RETINOPATHY STOMACH DISEASE OR ULCERS VEIN DISEASE, SKIN ULCER OR CHRONIC WOUND

EXPLAIN OTHER MEDICAL INFORMATION: _____

WHAT IS YOUR CURRENT HEIGHT _____ WEIGHT _____ SHOE SIZE _____ SHOE WIDTH _____

DO YOU SMOKE CIGARETTES, SMOKE A PIPE OR CHEW TOBACCO? yes no WHEN DID YOU QUIT? _____

HAVE YOU HAD PREVIOUS INJURIES TO YOUR FEET, ANKLES, LEGS OR BODY? yes no WHEN? _____

DESCRIBE ALL SURGERIES TO YOUR FEET, ANKLES, LEGS OR BODY. WHEN? DOCTOR WHO PERFORMED? _____

I UNDERSTAND THAT HONEST AND COMPLETE ANSWERS TO EACH QUESTION STATED ABOVE ARE IMPORTANT TO THE PROVISION ON MY MEDICAL CARE AND I HAVE ANSWERED THEM TO THE BEST OF MY ABILITY. I HAVE BEEN INFORMED THAT IF I AM UNCERTAIN OF ANY QUESTION ON THE FORM I SHOULD ASK THE DOCTOR OR A MEMBER OF THE OFFICE STAFF FOR ASSISTANCE.

Patient or legal guardian signature

Date



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HELPFUL PATIENT INFORMATION AND OFFICE POLICY DISCLAIMER

Any information provided to patients concerning insurance payment to Dr. Krell is not a guarantee of the patient's specific benefits. A general summary may be provided by Dr. Krell's office. Specific plan benefits, coverage, exclusions and limitations would be applied at the time the insurance company processes the claim. Any information given to us by an insurance company(s) representative is no guarantee of what will ultimately be paid. Dr. Krell's office will not be held responsible for incorrect, misleading or incomplete information provided by an insurance company. A patient's benefits and eligibility are subject to change without notice to the patient or Dr. Krell's office. All benefits may be subject to pre-existing conditions and limitations as specified in the patient's plan. Charges may or may not be applied to a network fee schedule. Benefits provided by your insurance company may be coordinated with other carriers if other coverage is involved.

Patients are ultimately responsible for the medical benefits, Dr. Krell is not.

Patients will be asked to call their insurance company to ask questions about their insurance benefits and to provide us with that information at the time certain services are provided or performed. Dr. Krell's office will not be responsible for the information an insurance company provides to us. The information may be incorrect, misleading or incomplete.

At the initial office visit or consultation, or at follow-up visits, some office procedures may NOT be performed. Patients may be asked to schedule a new, separate office visit for specific treatment or diagnostic procedures. This may include, but is not limited to, toenail, wart or minor office surgical procedures, treatment involving orthotics, radiology and diagnostic ultrasound services.

Patients will be asked to call their insurance carrier to discuss benefit information concerning orthotics, DME, diagnostic procedures or surgery prior to treatment. If unable to determine benefits, a patient will be asked to pay for the service in full and upon payment by the insurance company, Dr. Krell will issue the appropriate refund. Orthotic refunds may not be refunded at 100%. A reasonable fee may be deducted or a patient may be asked to pay for costs associated with the orthotics production. Custom orthotics, braces, certain DME products and goods will not leave the office until they are paid in full.

Patients will be responsible for paying outstanding bills in a timely fashion.

This information is part of Dr. Krell's office policy and patients are asked to sign and date below to acknowledge that they have read these statements.

Patient or legal guardian

Date

Disclaimer. July 25, 2008