Verona Foot Care, LLC

600 W RAILROAD AVE VERONA, PA 15147 (412)-794-8544

Welcome to Verona Foot Care! Please complete this form and return it to the front desk with your Insurance Cards, List of all medications, Photo ID, and Specialist Co-Pay. All information gathered here and in your patient file will remain strictly confidential; unless you direct otherwise.

PATIENT INFORMATION (CONFIDENTIAL)

PLEASE PRINT CLEARLY **DATE: _____**

Patient's Last Name	First Name	M.I	Age	Sex

By what Name do you wish to be called? _____
Birthdate_____ Single___ Married____ Widowed____Divorced/Separated____
S.S.N. _____ Home Phone_____
Work Phone _____ Cell Phone _____
Spouse's Name_____ Parent's Name (if minor) _____
EMERGENCY CONTACT_____ PHONE NUMBER_____
How did you hear about our office? _____

Social History: Do you: Smoke Tobacco? Yes ___ years No
Drink Alcohol Daily? Yes No
Consume Caffeine Daily? Yes No
Dentures Yes No
Vision Problems _____
Hearing Problems _____

ALLERGIES: _____
ARE YOU A DIABETIC? Yes No
Are you taking any medications? Yes No If yes, please provide a list

Primary Care Doctor: _____ Date Last Seen:_____
Pharmacy Name: _____ Phone #: _____
Height:_____ Weight: _____ Shoe Size: _____
Please Describe Your foot problem :

_____

_____

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SIGNATURE ON FILE

We use a computer to generate insurance claim forms in this office. This form will be placed in your file and used in place of your signature on our forms. Please read each line and initial in the blank space beside each line indicating that you have read and understand each line of the form.

_____ **I authorize use of this form on all my insurance claim submissions.**

_____ **I authorize release of all pertinent information to all my insurance companies.**

_____ **I understand I am ultimately responsible for my bill.**

_____ **I authorize my doctor to act as my agent in helping me obtain payment from my Insurance Companies.**

_____ **I authorize payment directly to Dr. Timothy P. Stewart.**

_____ **I permit a copy of this authorization to be used in place of the original.**

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

This signature acknowledgment that a copy of the Notice of Privacy Practices will be provided (and/or had the opportunity to read if I so choose) and understood the Notice. At the patient's request, a copy will be made available to take home as well. It is the patient's responsibility to read the notice.

Print Name _____ **Date** _____

DOB: _____

Signature: _____

Parent/ Authorized Representative (IF APPLICABLE): _____