Dr. Donnalyn Moeller, DPM, Inc.

Ph: 614-272-8854 Fax: 614-272-9200

3131 West Broad St. Columbus, Ohio 43204

Today's Date:______________________

Name:_________________________________ Email:____________________________

Date of Birth:____________ Age:______ Height:_______ Weight:______ Shoe Size:_______

Home Address:____

City:________________ State:_________ Zip Code:_________ SSN:_________________

Phone:( )____________ Cell:( )____________ Work:( )_____________ Male/Female

Occupation:______________ Employer:______________ Length of Employment:________

Work Address:____________________ City:_______________ State:_____ Zip:________

Primary Care Physician:______________________ Who Requested You See Us?:_________

Preferred Pharmacy:_____________ Address:____________________ Phone:____________

Emergency Contact:___________________ Phone:_____________ Relationship:__________

Please provide the following insurance information and present your insurance cards to the receptionist.

Primary Insurance:	Secondary Insurance:
Name of Insurance:____________	Name of Insurance:____________
Effective Date:______________	Effective Date:______________
Subscriber Name:____________	Subscriber Name:____________
Subscriber DOB:____________	Subscriber DOB:____________
Subscriber SSN:____________	Subscriber SSN:____________
Relationship to Patient:__________	Relationship to Patient:__________

I hereby give permission to Dr. Donnalyn Moeller, DPM to administer treatment and to perform such procedures as may be deemed necessary in the diagnosis and/or treatment of the extremity condition. I also hereby assign to the above named physician to release any information required. I understand that I am financially responsible for any balance due on my account, including non-covered charges.

Signature of Responsible Party:____ Date:____________

I request payment of authorized Medicare benefits be made either to me or on my behalf to Dr. Donnalyn Moeller, DPM for any services furnished to me by this physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I understand that my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. In Medicare assigned cases, the physician or supplier agrees to accepts the charge determination of the Medicare carrier as the full charge, and the patient is only responsible for the deductible, the coinsurance and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

Signature of Beneficiary:____ Date:______________

Please describe why you are here to see the doctor by filling in the following.

What is the main problem: ______________________________

Where on your foot or ankle is it located: ______________________________

When did this begin: ______________________________

Was there an injury or accident: ______________________________

What makes this problem better or worse: ______________________________

What treatments have you attempted: ______________________________

Please list all Medical Problems you have had. (eg. High Blood Pressure, Diabetes, Asthma, Heart Disease, etc.)

______________________________ ______________________________

______________________________ ______________________________

______________________________ ______________________________

Please list all Surgeries and Hospitalizations with date. (eg. Heart Bypass 1984, Knee Scope 1990, etc.)

______________________________ ______________________________

______________________________ ______________________________

______________________________ ______________________________

Please list all Medications you are now taking or have taken over the past month.

Medication	Dose/Times per Day	Reason for Taking

Please list all Allergies and identify the reaction. (eg. Penicillin – difficulty breathing, Tape-rash, etc.)

____

____

Please list any Medical Problems that run in your family. (eg. Arthritis, Heart, etc.)

____

____

Please answer the following questions about Social History:

Marital Status: Single Married Other Name of Spouse/Parent: ______________

Spouse/Parent DOB: ______________ Number of Children at Home: ________ **Out of Home:** ________

Do you smoke? YES / NO / QUIT If yes, how many packs per day: ______________

Do you drink alcohol? YES / NO If yes, how many drinks per day: ______________

Do you use recreational drugs? YES / NO If yes, what types: ______________

Do you live in a house or apartment: ______________ On what floor: ______________

If you are ill or recovering from surgery, is there someone to assist you at home? ______________

Sports, Hobbies, Activities you enjoy: ______________

Please mark an "X" next to any problem you are currently having:

____Anemia	____Emphysema	____Kidney Problems
____Arthritis	____Epilepsy	____Leg Cramps/ Claudication
____Asthma	____Eye Problems/Glaucoma	____Liver Problems
____Bleeding Disorder	____Gout	____Pacemaker
____Blood Clots	____Hardware (Internal)	____Psychiatric Problems
____Cancer	____Heart Disease	____Rheumatic Fever
____Chest Pain or Angina	____High Blood Pressure	____Seizures
____Circulation Problems	____HIV Positive/ AIDS	____Stomach Ulcers
____Diabetes	____Hepatitis / Jaundice	____Stroke

____Others not listed: ______________________________

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<u>Privacy Practice Notice, Patient Confidentiality and Office Policies/Procedures</u>

I acknowledge that I was provided a copy of the **Privacy Practice Notice, Patient Confidentiality and Office Policies/Procedures.** I have read (or had the opportunity to read if I so choose by receiving a copy of said forms) and understood all notices and forms provided for signature.

<u>Patient Confidentiality Form:</u>

To ensure confidentiality of all our patients, it is the policy of our office to release information regarding our patient only to the patient. If you wish others to receive information regarding your care, you must sign a release. By signing this, you are giving our office staff permission to treating physicians, therapists, hospitals or pharmacists.

If you would like us to release patient information to someone other than those mentioned above, please list their names, telephone numbers and relationship to you.

Name	Relationship	Phone
____________________	____________________	____________________
____________________	____________________	____________________
____________________	____________________	____________________

<u>OR ,</u> I prefer no family members/friends be given any information ________ (Initials)

When we are trying to reach you by telephone, do we have permission to leave a message on your answering machine or your voice mail? Yes_______ No_______

Please keep in mind when you are calling our office, regarding your care, our staff will need to speak with you directly unless otherwise stated above.

Printed Name:____

Signature:____ **Date:**__________________