Dr. Donnalyn Moeller, DPM, Inc.

Ph: 614-272-8854 Fax: 614-272-9200 3131 West Broad St. Columbus, Ohio 43204

Today's Date:					
Name:	Em	Email:			
Date of Birth:	Age:	Height:	Weight:	Shoe Si	ze:
Home Address:					
City:	State:	Zip Code:_	SSN:	<u> </u>	
Phone:()	Cell:()	W	ork:()		Male/Female
Occupation:	Emplo	nployer:Length of Employment:		nent:	
Work Address:	7	City:	St	ate:Z	ip:
Primary Care Physician:_		W	ho Requested Yo	ou See Us?:_	
Preferred Pharmacy:	A	Address: Phone:			
Emergency Contact:		Phone:	Relationship:		
Please provide the following	g insurance info	ormation and pre	sent your insura	nce cards to t	he receptionist.
Primary Insura	nce:		S	econdary Inst	urance:
Name of Insurance:		Name of Insurance:			
Effective Date:		Effective Date:			
Subscriber Name:		Subscriber Name:			
	OB:		Subscriber DOB: Subscriber SSN:		
Subscriber SSN:			Relationship to Patient:		
I hereby give permission to Dr. deemed necessary in the diagnophysician to release any informaccount, including non-covered	Donnalyn Moelle osis and/or treatme nation required. I u	ent of the extremity of	er treatment and to p condition. I also her	erform such pro	ocedures as may be e above named
Signature of Responsible Party:		Date:			
I request payment of authorized any services furnished to me by Health Care Financing Admini payable for related services. It information necessary to pay the determination of the Medicare coinsurance and non-covered services.	y this physician. I stration and its age inderstand that my ne claim. In Medic carrier as the full of	authorize any holder ents any information signature requests t are assigned cases, t charge, and the patie	of medical informs needed to determin hat payment be mad he physician or sup int is only responsib	tion about me t e these benefits le and authorize plier agrees to a le for the deduc e charge determ	o release to the or the benefits as release of medica accepts the charge tible, the
Simply of Danafisian				Date	

What is the main problem:		
Where on your foot or ankle is it	located:	
When did this begin:	0.000.810.000.000.000.000	
Was there an injury or accident:		
What makes this problem better	or worse:	
What treatments have you atten	npted:	-
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lease list all Medical Problems	you have had. (eg. High Blood Press	sure, Diabetes, Asthma, Heart Disease, et
	<u> Market</u>	nA shell shell
lease list all Surgeries and Hos	oitalizations with date. (eg. Heart By	rpass 1984, Knee Scope 1990, etc.)
làssa list all Madinations vous		FileSt
Medication	re now taking or have taken over the <u>Dose/Times per Day</u>	
Market Control of the		
	ify the reaction. (eg. Penicillin – diffi	
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Privacy Practice Notice, Patient Confidentiality and Office Policies/Procedures

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.

Patient Confidentiality Form:

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
		-
OR . I prefer no family members/f	riends be given any information_	(Initials)
When we are trying to reach you hanswering machine or your voice in	y telephone, do we have permissio mail? Yes No	n to leave a message on your
Please keep in mind when you are with you directly unless otherwise	calling our office, regarding your castated above.	care, our staff will need to speak
Printed Name:		
Signature:]	Date: