Dr. Craig Wilkes

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NEW PATIENT FORM

FIRST NAME_____**LAST NAME**_____

ADDRESS_____ **CITY**_____ **STATE**_____ **ZIP**_____

CELL _____ **HOME** _____ **SEX** ____ **D.O.B** _____

SINGLE ☐ **MARRIED** ☐ **DIVORCED** ☐ **WIDOWED** ☐ **S.S #**_____

EMAIL ADDRESS: _____

EMPLOYER_____ **WORK PHONE** _____

WORK ADDRESS _____

PRIMARY LANGUAGE _____ **HOW DID YOU HEAR ABOUT US?** _____

WHOM MAY WE THANK FOR REFERRING YOU?_____ _____

BILLING ADDRESS IF DIFFERENT FROM ABOVE

FIRST NAME_____**LAST NAME**_____

ADDRESS_____ **CITY**_____ **STATE**_____ **ZIP**_____

EMERGENCY CONTACT

FIRST NAME_____**LAST NAME**_____

ADDRESS_____ **CITY**_____ **STATE**_____ **ZIP**_____

CELL _____ **HOME** _____

PRIMARY CARE PHYSICIAN

FIRST NAME_____**LAST NAME**_____

ADDRESS_____ **CITY**_____ **STATE**_____ **ZIP**_____

PHARMACY

NAME_____**PHONE**_____

ADDRESS_____ **CITY**_____ **STATE**_____ **ZIP**_____

Patient_____
Date_____

PRIMARY INSURANCE INFORMATION

INSURANCE: _____**ADDRESS**_____

CITY_____ **STATE**_____ **ZIP** _____ **PHONE** _____

ID NUMBER_____**GROUP NUMBER**_____

SECONDARY INSURANCE INFORMATION

INSURANCE: _____**ADDRESS**_____

CITY_____ **STATE**_____ **ZIP** _____ **PHONE** _____

ID NUMBER_____**GROUP NUMBER**_____

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize Dr. Craig Wilkes, Doctor of Podiatric Medicine, to release any medical of incidental information that may be necessary for medical benefit or in processing applications for financial benefit. This includes but is not limited to my insurance company, Rehabilitation Services, Social Security Administration, and Worker's Compensation.

CONSENT FOR TREATMENT: I HEREBY AUTHORIZE Dr. Craig Wilkes, Doctor of Podiatric Medicine to administer diagnostic and medical procedures as may be necessary for proper health care.

OFFICE POLICY ON PAYMENT: I understand that I am responsible for payment of all charges. As a courtesy, my insurance will be billed for me. It is my responsibility to pay any deductible, co-pay or any other balance not paid for by my insurance company. I authorize insurance benefits to be paid directly to the provider.

SIGNATURE _____DATE_____

Patient_____
Date_____

What problem have you come for today? _____

Have you had previous Podiatric care? Yes☐ / No☐

If yes, by whom _____

MEDICAL HISTORY
Smoking status: Smoker☐ Never Smoked☐ Former Smoker☐

Do you Drink Alcohol? Yes☐ / No☐

Please mark any condition you have or have had in the past.

☐AIDS/HIV	☐Convulsions	☐Phlebitis
☐Anemia	☐Diabetes	☐Pregnant
☐Arthritis	☐Difficulty Breathing	☐Sciatica
☐Back Pain	☐Edema (swelling)	
☐Bleeding Disorder	☐Gout	
☐Chest Pain	☐Heart Attack	
☐Cold Feet	☐High Blood Pressure	
☐Hepatitis	☐Kidney Disorder	

☐Other _____

SURGICAL HISTORY
Please list any past surgical procedures
_____
_____
_____

ALLERGIES Do you have any allergies or sensitivities? Yes☐ / No☐
Please mark all that apply.

☐Antibiotics	☐Codeine	☐Iodine
☐Sulfa Drugs	☐Morphine	☐Methiolate
☐Penicillin	☐Demerol	☐Aspirin
☐Tetanus Antitoxin	☐Local Anesthetics	☐Adhesive
☐Tape	☐Latex	

☐ Other_____

MEDICATIONS
Please list any medications you are currently taking and what they are for.

_____	_____	_____
_____	_____	_____
_____	_____	_____

FAMILY HISTORY
Please mark all that apply.
☐Diabetes ☐Heart Disease ☐High Blood Pressure ☐Cancer

☐Other _____

Height: _____ **Weight**:_____

Patient_____
Date_____

Thank you for choosing Craig Wilkes, D.P.M. as your health care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered part of your treatment. The following is a statement of our Financial Policy that we require you to read and sign prior to any treatment. All patients must complete our Information and Insurance form before seeing the doctor. Full payment is due at time of service. We accept Cash, Check, ATM Check Card, Visa and MasterCard.

Regarding Insurance Your Insurance policy is a contract between you and your insurance company; we are not a party in this contract. Please understand and know your policy. Please be aware that some, and perhaps all of the services provided may be non- covered services and are not reasonable and necessary under insurance and/ or Medicare. You are responsible for payment of services provided. In the event that your insurance coverage changes to a plan where we are not a participation provider, refer to the above paragraph.

HMO Plans: All co-pays must be satisfied each and every visit. There are no exceptions due to contracting and uniform compliance rules. You are responsible for getting proper referral and prior- authorization from your primary care doctor in advance to your appointments.

PPO Plans: We have agreed to accept the discounted rate from your plan, however all co-pays and deductibles are your responsibility.

Third Insurance Policies: Third insurance policies are not accepted.

Usual and Customary Rates Our practice is committed to providing the best treatment for our patients and we charge what is the usual and customary for our area. You are responsible for payment regardless of any insurance companies arbitrary determination of usual and customary rates.

Adult Patients Adult patients are responsible for full payment at time of service.

Minor Patients The adults accompanying a minor, and the parents (or guardians of the minor) are responsible for full payment. For unaccompanied minors, non-emergency will be denied unless charges have been pre- authorized to an approved credit plan; such as Visa, MasterCard, or payment by Cash, or Check at time of service has been verified.

Missed Appointments unless canceled at least 24 hours in advance, our policy is to charge $50.00 for missed appointments. Please help us to serve you better by keeping your scheduled appointments.

Billing Charges If you are unable to pay your co-pay at the time of your scheduled visit, you will be supplied with an envelope to mail in your payment. This must be postmarked the next business day following your appointment to avoid a $5.00 billing fee. All deductibles and outstanding co-pay amounts are due 5 days from date received. This date will be indicated on your statement. If we must bill you repeatedly for services there will be a $2.50 billing charge per mailing.

Thank you for understanding our Financial Policy. Please let us know if you have any questions or concerns. I have read the Financial Policy; I understand and agree to this Financial Policy.

X_____ Date _____

Signature of Patient or Responsible Party