PHILLIPS PODIATRY/ PATIENT INFORMATION

DATE _____

PATIENT NAME _____
LAST FIRST MIDDLE

DATE OF BIRTH _____ AGE _____

BILLING ADDRESS _____

CITY _____ STATE _____ ZIP _____

PHONE NUMBER _____

CELL PHONE NUMBER _____

LOCAL ADDRESS _____

CITY _____ ZIP _____

SOCIAL SECURITY NUMBER _____ SEX M / F S M W D

RETIRED Y / N EMPLOYED Y / N STUDENT Y / N

EMPLOYER _____ BUSINESS PHONE _____

PRIMARY INSURANCE _____

SECONDARY INSURANCE _____

FAMILY PHYSICIAN NAME _____ PHONE NUMBER _____

PHARMACY _____

REFERRED BY _____

REASON FOR CONSULTATION _____

WHAT MEDICATIONS ARE YOU CURRENTLY TAKING ? _____

_____

ARE YOU ALLERGIC TO ANY MEDICATIONS ? _____

EMERGENCY CONTACT AND PHONE NUMBER _____

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PLEASE CIRCLE IF YOU HAVE A PRIOR/CURRENT HISTORY OF:

ANEMIA

ASTHMA

ARTHRITIS

DIABETES TYPE 1 (CONTROLLED BY INSULIN)

DIABETES TYPE 2 (CONTROLLED BY DIET/ORAL MEDICATION)

HEART PROBLEMS

STROKE

EPILEPSY

CANCER

HEPATITIS A. B. C

KIDNEY / LIVER DISORDER

RHEUMATIC FEVER

SHORTNESS OF BREATH

EASY BRUISING

HIGH BLOOD PRESSURE

BLEEDING PROBLEMS

PARKINSONS

HIV / AIDS

ARE YOU CURRENTLY TAKING A BLOOD THINNER

COUMADIN	**XARELTO**	**ELIQUIS**	**PRADAXA**
WARFARIN	**SAVAYSA**	**HIGH DOSE ASPIRIN**	

MEDICARE AND OTHER INSURANCE AUTHORIZATION FOR PHILLIPS PODIATRY

SIGNATURE ON FILE

I AUTHORIZE USE OF THIS FORM ON ALL MY INSURANCE SUBMISSIONS.
I AUTHORIZE RELEASE OF INFORMATION TO ALL MY INSURANCE CARRIERS
I UNDERSTAND THAT I AM RESPONSIBLE FOR MY BILL
I AUTHORIZE MY DOCTOR TO ACT AS MY AGENT IN HELPING ME OBTAIN PAYMENT FROM MY INSURANCE CARRIERS.
I AUTHORIZE PAYMENT DIRECTLY TO MY DOCTOR.
I PERMIT A COPY OF THIS AUTHORIZATION TO BE USED IN PLACE OF THE ORIGINAL

SIGNATURE _____ **DATE**_____

TURN TO PAGE 3.....>

PHILLIPS PODIATRY

IT IS OUR GOAL TO STRIVE TO GIVE OUR PATIENTS THE BEST CARE POSSIBLE AND TO BE AVAILABLE TO PATIENTS WHEN THEY HAVE A PROBLEM.

THERE WILL BE A $50 CHARGE FOR ANY PATIENT WHO DOES NOT KEEP THEIR APPOINTMENT OR FAILS TO GIVE US A 24 HOUR CANCELLATION NOTICE. ALSO, PLEASE BE ADVISED THAT WE MAY NOT BE ABLE TO RE-SCHEDULE ANY PATIENT WITH 3 OR MORE MISSED APPOINTMENTS. WE ASK FOR YOUR COOPERATION IN HELPING US BETTER SERVE ALL OUR PATIENTS.

SIGNED..... DATE.....

TURN TO PAGE 4

* EL PASEO

PHILLIPS PODIATRY CORP.

DR. KENNETH PHILLIPS

74090 EL PASO #100, PALM DESERT, CA 92260

NOT

760-773-3338

ADVANCED BENEFICIARY NOT COVERED NOTICE

Patient: _____ Date: _____

DOB: _____

Medicare and/or Commercial Insurance Companies may or may not pay for the following checked services.

NAIL TRIMMING & CALLUS REMOVAL

[ ] 11720 / 11721 Routine Nail Care: $ 50

[ ] 11055 / 11056 Severely thickened Nails and/or Callus Trimming: $ 65

DIAGNOSIS

[ ] M79.671/2 Toe Foot [ ] M79.674/5 Toe Pain [ ] L84 Corns & Callosities

[ ] L60.3 Nail Dystrophy [ ] L60.0 Nail Cryptosis [ ] B35.1 Nail Mycosis

I understand that Medicare and/or Commercial Insurance Companies may or may not cover the above services. I am responsible for the amount listed above and I accept the terms of this service.

SIGNATURE: _____ DATE: _____