Thomas J. Savage, DPM Jay H. Dworkin, DPM PC

1421 S. Potomac Street, Suite 120

Aurora, CO 80012

303.923.3369 www.metrofoot.org 303.923.3882(fax)

Please print and complete all parts. **Date_____**

PATIENT INFORMATION

Name _____ Male _____ Female_____

Address_____ Apt #_____

City_____ State _____ Zip _____ Social Security #_____

Home Phone _____ Work _____ Cell _____

Email Address_____ Text message reminders Yes_____ No____

Date of Birth _____ Age_____ Single____ Married____ Widowed____ Divorced_____

Referred by _____ Primary Care Physician_____

Pharmacy _____ Pharmacy Phone Number_____

Employed Yes ___ No ___ Employer _____ Work Injury Yes___ No ___

Chief Complaint/ Reason for visit _____

INSURANCE INFORMATION (Please provide insurance cards at time of appointment)

Primary Insurance_____ Member ID # _____

Subscriber Name _____ Subscriber Date of Birth _____

Deductible $ _____ Deductible Amount Met $_____ Copay $_____

Secondary Insurance_____ Member ID # _____

Subscriber Name _____ Subscriber Date of Birth _____

Assignment of benefits: I authorize payment of medical benefits to Dr. Thomas J. Savage or Dr. Jay H. Dworkin for services provided to me. I authorize the release of any medical information necessary to process this and all future claims. I understand that I, not the insurance company, am the responsible party for all fees incurred.

X_____ _____

Signature Date

Dr. Thomas J. Savage DPM and Dr. Jay H. Dworkin DPM, PC, are independent Foot & Ankle Podiatric Physicians sharing the office of Dr. Thomas J. Savage DPM (Metropolitan Foot & Ankle Specialist).

MEDICAL INFORMATION

DO YOU HAVE ANY OF THE FOLLOWING? (PLEASE WRITE YES OR NO)

MEDICAL HISTORY

Diabetes _____
Gout _____
Epilepsy _____
Parkinson's _____
Cancer _____
Hepatitis _____
Thyroid Disease _____
Skin Disorder _____
Stomach Ulcers _____
Poor Circulation _____
HIV+ _____
Heart Disease _____
High or Low Blood Pressure_____
Angina _____
Heart Murmur_____
Asthma _____
Emphysema _____
Blood Clots _____
Kidney Disease _____
Neuropathy _____

REVIEW OF SYSTEMS

HEART/CIRCULATION
Y____ N____ Palpitations
Y____ N____ Chest Pain
Y____ N____ Leg Swelling
Y____ N____ Leg Cramps/ Pain when walking
Y____ N____ Past Heart Attach/ Bypass

RESPIRATORY
Y____ N____ Shortness of Breath
Y____ N____ Cough or Wheezing
Y____ N____ Tuberculosis
Y____ N____ Pulmonary Embolism

DIGESTIVE
Y____ N____ Weight gain/loss
Y____ N____ History of Ulcers
Y____ N____ Blood in Stool
Y____ N____ Diarrhea/ Constipation
Y____ N____ Stomach Pain or Cramps

URINARY
Y____ N____ Frequent Urination
Y____ N____ Burning
Y____ N____ Blood in Urine
Y____ N____ Frequent Urinary Infections

NEUROLOGICAL
Y____ N____ Headaches
Y____ N____ Seizures/ Convulsions
Y____ N____ Tingling/ Burning/ Pain
Y____ N____ Neuropathy (Loss of Feeling)

PHYCHOSOCIAL
Y____ N____ Anxiety
Y____ N____ Depression
Y____ N____ RSD
(Reflex Sympathetic Dystrophy)

SKIN
Y____ N____ Itching/ Burning
Y____ N____ Discoloration
Y____ N____ New Spots/ Ulcerations/ Wounds

EYES/ EARS/ NOSE/ MOUTH
Y____ N____ Visual Changes
Y____ N____ Hearing Difficulties
Y____ N____ Sinus or Mouth Problems

MUSCLE/ JOINTS/ BONES
Y____ N____ Arthritis
Y____ N____ Osteoporosis

BLOOD
Y____ N____ Bleeding Disorder
Y____ N____ Anemia

SOCIAL

Employed Y____ N____ Smoke Y____ N____ Alcohol Y____ N____ Drug Use Y____ N____

MEDICATIONS (PLEASE LIST OR PROVIDE A LIST)

_____
_____
_____
_____
_____

ALLERGIES (i.e. Aspirin, Penicillin, Codeine, Iodine, Adhesive tape, Latex, Etc.)

_____
_____
_____
_____
_____

FAMILY HISTORY (i.e., Diabetes, Heart, Cancer, Foot Problems)

_____
_____
_____
_____
_____

PAST SURGICAL HISTORY (List type of surgery, when, and if any complications)

_____
_____
_____
_____
_____

ANY OTHER INFORMATION YOU THINK WE SHOULD KNOW?

_____
_____
_____
_____

THANK YOU FOR TAKING THE TIME TO ACCURATELY COMPLETE THIS INFORMATION!!

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Office Financial Policy and Guidelines

FINANCIAL AGREEMENT:

1. Medical services are requested and provided directly to the patient and not the insurance company.
2. Patient is responsible for all co-pays, deductibles and all non-covered services at the time of service. Including co-pays and deductibles for surgery.
3. Patient is responsible for obtaining any referrals that are required.
4. It is the patient's responsibility to provide us with the correct, most up to date insurance information, including a copy of the most recent insurance identification card.
5. Secondary insurance will be billed as a courtesy.
6. If the patient's insurance is found not to be in effect on the date of services are provided, patient will be responsible for the full balance with **NO** discounts.
7. A collection fee will be added to all outstanding debt, and the account will be placed with a collection agency, all attorney fees and collection agency fees will be charged back to the patient.

OFFICE GUIDELINES:

1. Our office welcomes treatment for all patients, including children. All children under the age of 17 must have a parent or legal guardian present at all appointments.
2. For the safety, comfort, and privacy of our patients and employees, one friend or family member will be permitted to accompany a patient in the treatment room during the appointment.
3. Missed appointments will be charged a $50.00 for any missed appointment without 24-hour advance notice.
4. We request all cellular phones be turned off or set to silent during your appointment.
5. We reserve the right to dismiss any patient from our practice for any inappropriate behavior in our office or on the phone.

I have read the above policies and guidelines and agree with the terms outlined for the office of Dr. Thomas J. Savage DPM and Dr. Jay H, Dworkin DPM, PC.

_____ _____

Signature of Responsible Party Date

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