

DEMOGRAPHICS SHEET

1. PATIENT INFORMATION:

DATE _____ DOB _____ GENDER M F
LAST NAME _____ FIRST NAME _____
NAME OF FACILITY _____ CITY _____
 INDEPENDENT LIVING ASSISTED LIVING APARTMENT NUMBER _____
PHARMACY _____ CROSS STREETS _____
PRIMARY CARE DOCTOR NAME _____ PHONE NUMBER _____

2. BILL TO PARTY INFORMATION:

NAME _____ RELATIONSHIP TO PATIENT _____
ADDRESS _____
PHONE NUMBER _____

3. INSURANCE INFORMATION:

PRIMARY INSURANCE _____ PPO HMO PHONE _____
PRIMARY POLICY ID NUMBER _____ GROUP NUMBER _____
CLAIMS ADDRESS _____
SECONDARY INSURANCE _____ PPO HMO PHONE _____
SECONDARY POLICY ID NUMBER _____ GROUP NUMBER _____
CLAIMS ADDRESS _____

4. PLEASE INCLUDE COPIES OF BOTH SIDES OF ALL HEALTH INSURANCE CARDS. THANK YOU!

PODIATRY SERVICES

RESIDENT'S NAME: _____

FACILITY NAME: _____

We can assist you in having your loved one receive podiatry services in your residence. The fee for this service is not included in the monthly rental fee and will be billed by the physician's office. In some cases, this fee may be paid by Medicare. However, if it is determined that this service will not be covered by Medicare or another form of insurance, you will be billed directly for the service.

The discounted charge for each podiatry visit is a flat fee of \$95.00 for a New Patient and \$85.00 for an Established Patient. This service includes review of medical information, evaluation and examination of feet, debridement of all nails, corns and calluses.

All information for new patients is required prior to rendering care. This includes medical history, list of medications, copy of both sides on insurance cards, and POA consent. Please visit our website at www.onyourfeetaz.com to access the new patient packet. Click on the "Forms" tab at the top of the page then on "House Call." Please fax or mail the information to our office.

PLEASE SELECT ONE:

YES, I want my loved one to receive podiatry services.

NO, I do not care to receive podiatry services at this home.

POA Printed Name: _____

POA Relationship To Resident: _____

POA Signature: _____

Date: _____