WELCOME TO OUR OFFICE

CHART #: ____________________

For Office Use Only
Office: ❑ Athens ❑ Madison
Provider: ❑ Dr. Blasingame

PATIENT INFORMATION FORM

The Foot Group, P.C.

Dr. Tara L. Blasingame,DPM
P.O. Box 6487
Huntsville, AL 35813-0487
(256)772-8566 * (256)232-2009

Today's Date: _____________

Referred By: ______________

ALL INFORMATION IS STRICTLY CONFIDENTIAL

GENERAL

(PLEASE PRINT CLEARLY)

PATIENT'S NAME ____ BIRTHDATE ______________
(LAST) (FIRST) (MIDDLE) (MONTH, DATE, YEAR)

PATIENT'S SOCIAL SECURITY NUMBER ______________________________ PATIENT'S SEX: ❑MALE ❑FEMALE

ADDRESS ____ ZIP CODE ___________
(STREET) (CITY) (STATE)

HOME PHONE ( ) ______________________ WORK PHONE ( ) ______________________
AREA CODE AREA CODE

EMPLOYER ______________________________ ADDRESS ______________________________

NAME OF SPOUSE (OR PARENT) ______________________ ADDRESS ______________________

SOCIAL SECURITY NUMBER ______________________________ PHONE ( ) ______________
AREA CODE

MEDICAL

CHIEF COMPLAINT/REASON FOR VISIT ____

DATE OF LAST GENERAL PHYSICAL EXAM ____
(MONTH-YEAR) (PHYSICIAN)

LIST ANY MEDICATIONS YOU ARE CURRENTLY TAKING __________________________________

LIST ANY ALLERGIES YOU HAVE (DRUGS, FOOD, HAY FEVER, OTHER) ______________________

DESCRIBE ANY CONDITIONS WE SHOULD KNOW ABOUT ______________________ SHOE SIZE ___________

DO YOU HAVE HIGH BLOOD PRESSURE? ______________________ DIABETES? ______________

ARE YOU SEEING THE DOCTOR BECAUSE OF AN ACCIDENT? ______________________________

INSURANCE

PRIMARY INSURANCE COMPANY ______________________________ POLICY # ________________

INSURED NAME ______________________________ SOCIAL SECURITY # ________________

RELATIONSHIP TO PATIENT ______________________ DATE OF BIRTH ______/______/_______
Month Day Year

SECONDARY INSURANCE COMPANY ______________________________ POLICY # ________________

INSURED NAME ______________________________ SOCIAL SECURITY # ________________

RELATIONSHIP TO PATIENT ______________________ DATE OF BIRTH ______/______/_______
Month Day Year

FINANCIAL

I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES FOR SERVICES TO ME INCLUDING THE BALANCE REMAINING AFTER PAYMENT OF POSSIBLE INSURANCE BENEFITS. I HEREBY AUTHORIZE DR. TARA L. F. BLASINGAME, DPM TO FURNISH INFORMATION TO INSURANCE CARRIERS CONCERNING MY ILLNESS AND TREATMENTS. I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY AMOUNT NOT COVERED BY INSURANCE. IN THE EVENT I DO NOT PAY MY BILL, I AGREE TO PAY ALL COSTS OF COLLECTION, INCLUDING A REASONABLE ATTORNEY'S FEE IN THE EVENT THAT IT IS NECESSARY TO EMPLOY AN ATTORNEY TO ENFORCE ANY PROVISIONS OF THIS CONTRACT. I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO THE NAMED PROVIDER FOR PROFESSIONAL SERVICES RENDERED. I HAVE READ AND UNDERSTAND THE FINANCIAL POLICY OF THE FOOT GROUP, P.C.

SIGNED ____ DATE ________________
(PATIENT, OR IF MINOR)