

Western Reserve Foot Clinic

Dr. Kenneth H. Nixon

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**\*\*PLEASE PRINT LEGIBLY\*\***

Patient Name: \_\_\_\_\_ Birth Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Street Address: \_\_\_\_\_ Home Phone \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_ Zip Code \_\_\_\_\_ Soc. Security# \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ \*Required

Email address \_\_\_\_\_ (Circle one) Male Female

Cell phone \_\_\_\_\_ Permission to contact by Text (circle one) YES NO

**\*Whom may we discuss your medical/financial information with?\***

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_

Marital Status: Married  Single  Divorced  Widowed

Ethnicity: Hispanic  Non Hispanic  Race: White  African American  Other

(Above now can be required for government quality reporting)

Primary Care Physician \_\_\_\_\_ Date Last Seen \_\_\_\_\_

Preferred Pharmacy and Location \_\_\_\_\_ Pharmacy Phone \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Phone \_\_\_\_\_

Name Primary Card Holder Insurance \_\_\_\_\_ Relationship \_\_\_\_\_

\*Card Holder Date of Birth \_\_\_\_\_ and SS# \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ \*Required

**Medicare/Insurance Beneficiaries/Patients:**

I hereby request that payments by Medicare/Insurance be payable on my behalf to Hudson Foot Clinic DBA Western Reserve Foot Clinic (WRFC) for services provided. I authorize any medical information to be released to any entity involved in my care or billing for insurance and claims. I agree to be responsible for any remainder left after amount not covered by insurance or co-insurance including deductibles and co-pays at time of service. I understand WRFC does not provide care under Workers Compensation.

I hereby give WRFC permission to retrieve medication history from a pharmacy benefit manager.

WRFC adheres to all regulations set forth by the HIPAA Privacy act and hereby acknowledge that I was able to read online or was given the opportunity to see a copy of the Privacy Notice.

I hereby give WRFC permission to examine and provide treatment that is medically indicated.

I agree to provide payment in a timely manner for amounts due to the physician. These charges include but are not limited to Co-pays, deductibles, office provided medical goods, charges denied by my insurance program or considered not medically necessary. Also, may include, treatments, injections, orthotics, braces walking boots, surgeries, routine or cosmetic care not covered by health insurers contract.

\_\_\_\_\_  
Printed Name of Patient/Guardian

\_\_\_\_\_  
Signature of Patient/Guardian

\_\_\_\_\_  
Date

WESTERN RESERVE FOOT CLINIC

DR. KENNETH NIXON

MEDICAL HISTORY INFORMATION

Patient Name \_\_\_\_\_

Date \_\_\_\_\_

Current Foot/Ankle problem \_\_\_\_\_

Due to accident? Yes  No  \*No Workers Comp. Accepted\*

Past medical history: (Circle all that apply)

AIDS/HIV Arthritis Asthma Cancer Diabetes Depression/Anxiety Gout

Heart Hepatitis High Blood Pressure Kidney Osteopenia/Osteoporosis

Psychiatric Stomach Ulcers Stroke Vascular disease Varicose Veins

List any other medical issues not listed \_\_\_\_\_

Social History: Smoker \_\_\_\_\_ Alcohol \_\_\_\_\_ Drug Use \_\_\_\_\_

ALLERGIES: **\*\*List any allergies and what reaction occurred\*\*** \_\_\_\_\_

MEDICATIONS – List all including prescriptions, vitamins and supplements: \_\_\_\_\_

SURGERIES- List All: \_\_\_\_\_