

Western Reserve Foot Clinic

4495 Darrow Rd.

Stow, OH 44224

Email - drfootclinic@gmail.com

Dr. Kenneth H. Nixon

Phone 330-689-3338

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****PLEASE PRINT LEGIBLY****

Patient Name: _____ Birth Date ____/____/____

Street Address: _____ Home Phone _____

City _____ State ____ Zip Code _____

Email address _____ (Check one) Male Female

Cell phone _____ Permission to contact by Text (Check 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: _____

WESTERN RESERVE FOOT CLINIC

DR. KENNETH NIXON

How did you hear about the practice? (circle one)

Internet/Google _____

Friend/Family _____

Doctor Referral (who?) _____

Insurance Company _____

Facebook _____

Other _____