Western Reserve Foot Clinic | Dr. Kenneth H. Nixon
4495 Darrow Rd. | Phone 330-689-3338
Stow, OH 44224 Email - drfootclinic@gmail.com | Fax 330-689-0282

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_______________ *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:____

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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**______________________________________