Western Reserve Foot Clinic
4495 Darrow Rd.
Stow, OH 44224 Email - drfootclinic@gmail.com

Dr. Kenneth H. Nixon
Phone 330-689-3338
Fax 330-689-0282

PLEASE PRINT LEGIBLY

Patient Name:_____ Birth Date _____/_____/_____

Street Address:_____ Home Phone_____

City_____State____ Zip Code_____

Email address_____ (Check one) Male☐ Fema☐

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:_____

_____