Arrowhead Podiatry Associates

Beau Bortel, DPM, FACFS

Diseases, Deformities, & Injuries *of the Foot and Ankle*

5757 Monclova Rd. Suite 5
Maumee, OH 43537

Ph: 419-893-5757
Fax: 419-893-5399

Welcome and thank you for choosing Arrowhead Podiatry Associates. Our focus is on your overall health and well-being. We believe in tailored care to fit your needs, not a one-size fits all approach! Enclosed you will find a new patient information packet. We ask that you complete all forms prior to your upcoming visit.

As a reminder, your appointment is scheduled with Dr. Beau Bortel on:

_____ at _____.

Please check with your insurance provider to be sure that Dr. Beau Bortel is in network, or if a referral is required to see a specialist. Please be aware it is the patient's responsibility to obtain these referrals. The patient may be held accountable for an office visit charge if the referral is not current at the time of service.

Please bring the completed forms, all insurance cards, and a photo ID to your scheduled appointment. If you do not have your insurance cards at time of service you will be required to reschedule your appointment.

If you have any questions or concerns, or if you are unable to keep your appointment for any reason, please contact the office at **419-893-5757** as soon as possible so that we may reschedule your appointment.

Sincerely,

Arrowhead Podiatry Associates

ARROWHEAD PODIATRY ASSOCIATES, INC.
PATIENT REGISTRATION FORM

Name: _____ □ Mr. □ Mrs. □ Miss □ Ms.
LAST FIRST MI

Street Address: _____ City: _____

State: _____ Zip Code: _____ Email: _____

Primary Phone Number: _____ Alternate Phone Number: _____

Date of Birth: _____ Social Security Number: _____ Sex: □ Male □ Female

Marital Status: □ Married □ Single □ Divorced □ Widow If Married, Spouse's Name: _____

Occupation: _____ Employer: _____ Employer Phone #: _____

Pharmacy: _____ Pharmacy Phone #: _____

REFERRAL INFORMATION: Who may we thank for referring you to our office?

□ Insurance Plan □ Hospital □ Dr. _____ □ Family Member _____

□ Internet Search □ Close to Home/Work □ Other □ Friend _____

PRIMARY INSURANCE INFORMATION:

Name of Insured: _____

Insurance Company: _____

Policy Number: _____

Group Number: _____

Main Policy Holder: _____

Relationship to Patient: _____

SECONDARY INSURANCE INFORMATION:

Name of Insured: _____

Insurance Company: _____

Policy Number: _____

Group Number: _____

Main Policy Holder: _____

Relationship to Patient: _____

IN CASE OF EMERGENCY:

Emergency Contact: _____ Relationship to Patient: _____

Emergency Contact Phone #: _____ Secondary Contact Phone #: _____

I give my permission to Beau Bortel, DPM to diagnose and treat my medical condition and therefore authorize benefits paid to this physician for services rendered. I also authorize the release of any information deemed necessary to process this claim and request payment to be made to Arrowhead Podiatry Associates, Inc.

Patient/Guardian Signature _____ **Date** _____

ARROWHEAD PODIATRY ASSOCIATES, INC.

PATIENT REGISTRATION FORM, page 2

FOOT HEALTH INFORMATION:

Main foot complaint today:

_____

_____

_____

_____

Location: _____

Is the problem the result of an injury?

□ YES □ NO

If Yes, Date of Injury: _____

How did the injury occur?

_____

_____

_____

PERSONAL MEDICAL HISTORY:

1.) Primary Care Physician _____ Phone #:_____

2.) Do you have any allergies to medications? □ YES □ NO

If yes, what medications _____

_____

3.) Have you ever had problems with anesthesia? □ YES □ NO

If yes, please explain _____

_____

4.) Are you a Diabetic? □ YES □ NO

5.) Do you have any bleeding problems? □ YES □ NO

If yes, please explain _____

6.) Do you use tobacco products? □ YES □ NO

7.) Have you ever been treated for asthma, circulation (vascular) problems, epilepsy, heart trouble, kidney or liver problems, or rheumatic fever? □ YES □ NO

If yes, please explain _____

_____

8.) Please list all previous surgical procedures:_____

_____

_____

HEIGHT: _____ WEIGHT: _____

Medication List

Patient Name: _____ Date: _____

Allergies to Medications:

_____

_____

_____

Medication	Dose	Times Per Day

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Arrowhead Podiatry Associates follows all guidelines of HIPAA-THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT.

A copy of the HIPAA policy is available for review in the office.

This policy is also available at
http://www.hhs.goc/ocr/privacy/hipaa

_____

Print Patient Name

_____

Signature

_____

If Signed by Personal Representative, Relationship to Patient