

**John M. Galant, DPM**

**Primary Physician:** \_\_\_\_\_

**Date Last Seen:** \_\_\_\_/\_\_\_\_/\_\_\_\_

**Patient Information**

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ MI: \_\_\_\_\_

Race: *White/Asian / Black-African Amer /Amer. Indian / Alaska Native / Native Hawaiian / Other Pacific Islander / Other*

Ethnicity: *White / Asian /African Amer / Hispanic*

Marital Status: *Single/Married/Widowed/Divorced/Separated* Maiden Name: \_\_\_\_\_

SSN: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_ AGE: \_\_\_\_\_ Gender: *Male/Female*

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Home Phone: (\_\_\_\_) \_\_\_\_\_ Work Phone: (\_\_\_\_) \_\_\_\_\_ Cell Phone: (\_\_\_\_) \_\_\_\_\_

Email: \_\_\_\_\_ Preferred Method of Contact: \_\_\_\_\_

Employment Status: \_\_\_\_\_ Employer: \_\_\_\_\_

Occupation: \_\_\_\_\_

**Reason for Visit:** \_\_\_\_\_

**Whom may we thank for referring you to our practice:** \_\_\_\_\_

**Responsible Party Information (Person to whom the bill should be sent)**

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ MI: \_\_\_\_\_

Relation with patient: \_\_\_\_\_ SSN: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_

Gender: *Male/Female*

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

**Insurance Information**

Insurance Carrier: \_\_\_\_\_

Policy Holder's Name: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

Insured Id: \_\_\_\_\_ Effective Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Expiration Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Group Name: \_\_\_\_\_ Group Number: \_\_\_\_\_

**Insured: SELF \_\_\_\_\_ IF NOT:**

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ MI: \_\_\_\_\_

Relation with patient: \_\_\_\_\_ SSN: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

**Secondary** Payer Name: \_\_\_\_\_

**Emergency Contact**

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Home Phone:(\_\_\_\_) \_\_\_\_\_ Work Phone: (\_\_\_\_) \_\_\_\_\_ Cell Phone:(\_\_\_\_) \_\_\_\_\_

**Medical Information**

**Pharmacy Name:** \_\_\_\_\_ **City/Town & State:** \_\_\_\_\_

**Medications:** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**HEIGHT:** \_\_\_\_\_ **WEIGHT:** \_\_\_\_\_ **BLOOD PRESSURE:** \_\_\_\_\_ **SHOE SIZE:** \_\_\_\_\_

**Smoking:** Current Smoker: Years Smoking: \_\_\_\_\_; \_\_\_\_\_ packs/day \_\_\_\_\_ yrs smoking  
Stopped Smoking: \_\_\_\_\_ When did you stop: \_\_\_\_\_ years Never Smoked: \_\_\_\_\_

**Allergies:** \_\_\_\_\_

**Past Surgery(ies) (with dates):** \_\_\_\_\_

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

- |                                 |                              |                             |                     |                              |                             |                          |                              |                             |
|---------------------------------|------------------------------|-----------------------------|---------------------|------------------------------|-----------------------------|--------------------------|------------------------------|-----------------------------|
| AIDS/HIV                        | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Diabetes            | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Plantar Warts            | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Allergies to Anesthetics        | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Ear Problems        | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Psychiatric Care         | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Allergies to Medicine or Drugs  | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Epilepsy            | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Radiation Treatment      | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Anemia                          | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Eye problems        | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Rash                     | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Angina                          | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Fainting            | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Respiratory Disease      | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Ankle Pain                      | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Flat Feet           | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Rheumatic Fever          | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Arthritis                       | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Foot or Leg Cramps  | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Shortness of Breath      | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Artificial Heart Valves/Joints  | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Gout                | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Sinus Problems           | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Asthma                          | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Headaches           | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Special Diet             | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Athlete's Foot                  | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Heart Disease       | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Stroke                   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Back Problems                   | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Heel Pain           | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Swelling in Ankles, Feet | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Bleeding Disorders              | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Hemophilia          | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Swollen Neck Glands      | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Bunions                         | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Hepatitis/Jaundice  | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Tired Feet               | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Cancer                          | <input type="checkbox"/> Yes | <input type="checkbox"/> No | High Blood Pressure | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Tuberculosis             | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Chemical Dependency             | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Ingrown Toenails    | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Ulcers                   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Chest Pain                      | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Kidney Problems     | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Varicose Veins           | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Chronic Diarrhea                | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Liver Disease       | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Venereal Disease         | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Circulatory Problems            | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Low Blood Pressure  | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Weight Loss, unexplained | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Corns and Calluses              | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Neuropathy          | <input type="checkbox"/> Yes | <input type="checkbox"/> No |                          |                              |                             |
| Cramps or Numbness in Feet/Legs | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Phlebitis           | <input type="checkbox"/> Yes | <input type="checkbox"/> No |                          |                              |                             |

**Other Known Illnesses:** \_\_\_\_\_

**Insurance Authorization and Assignment**

*I REQUEST THAT PAYMENT OF AUTHORIZED MEDICARE OR OTHER INSURANCE COMPANY BENEFITS BE MADE ON MY BEHALF TO DR JOHN M. GALANT, DPM FOR ANY SERVICES FURNISHED TO ME BY HIM. I AUTHORIZE ANY HOLDER OF MEDICAL INFORMATION ABOUT ME TO RELEASE TO CMS, ITS AGENTS OR MY INSURANCE ANY INFORMATION NEEDED TO DETERMINE THESE BENEFITS PAYABLE FOR RELATED SERVICES.*

*FURTHERMORE, I UNDERSTAND THAT ANNUAL DEDUCTIBLE AMOUNTS AND ALL CO-INSURANCE AMOUNTS ARE MY RESPONSIBILITY. IF I ASSIGN MY MEDICAL BENEFITS TO ANY OTHER PARTY (HMO), RENDERING THIS OFFICE INELIGIBLE FOR PAYMENTS, I UNDERSTAND THAT I WILL BE RESPONSIBLE FOR THE ENTIRE BILL FOR SERVICES RENDERED TO ME. I ALSO UNDERSTAND AND AGREE THAT IF THIS ACCOUNT MUST BE REFERRED TO AN ATTORNEY OR COLLECTION AGENCY, I SHALL BE RESPONSIBLE FOR ALL REASONABLE EXPENSES. INCURRED. THESE COSTS MAY INCLUDE, BUT BE LIMITED TO: COLLECTION AGENCY OR ATTORNEY FEES, AND INTEREST AT THE MAXIMUM ALLOWABLE LEGAL RATE. FURTHERMORE, I UNDERSTAND THAT IF, FOR ANY REASON, I SHOULD CHOOSE THE DRUGS OR TREATMENT OPTIONS RECOMMENDED OR REQUIRED BY MY INSURANCE CARRIER, INSTEAD OF THE TREATMENT PRESCRIBED BY DR. GALANT, I AGREE TO HOLD DR GALANT HARMLESS FOR INADEQUATE OR ADVERSE THERAPEUTIC RESULTS RELATED TO THAT CHOICE.*

*I UNDERSTAND MY SIGNATURE REQUESTS THAT PAYMENT BE MADE AND AUTHORIZE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PAY THE CLAIM IN MEDICARE OR INSURANCE COMPANY ASSIGNED CASES. THE PHYSICIAN AGREES TO ACCEPT THE CHARGE DETERMINED BY MEDICARE OR MY INSURANCE COMPANY AS PAYMENT IN FULL. I AM RESPONSIBLE FOR ANY DEDUCTIBLE, COINSURANCE, OR NON-COVERED SERVICES.*

*I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES. I HAVE READ THIS INFORMATION AND FULLY UNDERSTAND IT*

**SIGNATURE:** \_\_\_\_\_ **DATE:** \_\_\_\_\_

**Your health information will be kept confidential. Any information we collect about you on this form will be kept confidential in our office. Your health information will be shared with insurance carriers for billing purposes only.**