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

Other Known Illnesses: _____

Insurance Authorization and Assignment
& acknowledgment of receipt of notice of privacy practices

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 ANDALL 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 INTERESTAT THE MAXIMUM ALLOWABLE LEGAL RATE. FURTHERMORE,I UNDERSAND 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 RESPONCIBLE FOR ALL CHARGES. I HAVE READ THIS INFORMATION AND FULLY UNDERSTAND IT
I ACKNOWLEDGE THAT I WAS PROVIDED A COPY OF THE NOTICE OF PRIVACY PRACTICES AND THAT I HAVE READ (OR HAD THE OPPORTUNITY TO READ IT IF I SO CHOSE) AND UNDERSTOOD THE NOTICE.

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.