Wayne V. Videtich, D.P.M., P.C.

Podiatrist

2710 South Street, Lincoln, NE 68502

PATIENT INFORMATION

Date of Visit:_____

❑ New Patient Student

❑ Update Full ❑ Part ❑

Name: _____
Last First Middle

Address: _____ City/State: _____ Zip Code: _____

Home Phone: _____ Work Phone:_____ Cell phone:_____

Sex: M F Date of Birth: ____/____/____ Age: _____ Height: _____ Weight: _____ Marital Status: S M D W

Race: Caucasian _____ Black _____ American Indian _____ Asian _____ Other _____

Ethnicity: Hispanic _____ Non-Hispanic _____ Declined _____

Preferred Language: _____

Social Security No: _____ **Banking Institution** _____

(required or payment, in full, is due at time of service)

Employer name: _____ Occupation: _____

Employer address: _____

Spouses Name: _____ Date of Birth ____/____/____

Spouses SS#: _____ Work Phone: _____ Cell Phone:_____

Name of Emergency Contact **not** living with you: _____

Relationship:_____ Home Phone: _____ Work Phone:_____ Cell Phone: _____

REFERRAL: _____ Doctor _____ Family/Friend _____Phone Book _____ Location _____Internet

Name: _____ Address:_____

INSURANCE COVERAGE INFORMATION: A copy of your card(s) is necessary

Primary Insurance Company:_____

Responsible Party (if patient is a minor)

Fathers Name: _____ Mothers Name: _____

Address:_____ Address:_____

Street Street

_____ _____

City State Zip City State Zip

Employer:_____ Employer:_____

Date of Birth: ___/___/____ Date of Birth: ___/___/____

Social Security #:_____ Social Security #:_____

(required) **(required)**

Home Phone:_____ Home Phone:_____

Work Phone:_____ Work Phone:_____

Cell Phone:_____ Cell Phone:_____

Authorization: I have read and agree to the terms and conditions on the reverse side of this form and I hereby authorize the release of any medical information necessary to process my health insurance and request payment of benefits to the provider of services. I understand I am financially responsible to Wayne V. Videtich, D.P.M. for charges not covered or denied by my insurance company.
I further agree in the event of my non-payment, to pay the cost of collection and/or court costs and reasonable fees should this be required.

*Patient/Guarantor Signature*_____ *Date*_____

FINANCIAL POLICY

We would like to take this opportunity to welcome you to our office, and to let you know we are committed to providing you with the best possible care. So there is no misunderstanding as to what our Financial Policy is, please take this time to read this information. We will gladly discuss your proposed treatment and answer any questions relating to your insurance.

If you have no insurance, payment for services is due at the time services are rendered unless payment arrangements have been approved in advance. To assist you, we accept, cash, checks, VISA, MasterCard, or Discover.

If you have insurance, we will file it for you as a courtesy provided we have your assignment of benefits. You must realize, however, that your insurance is a contract between you and your insurance company. Payment to us is your responsibility. If at the end of 45 working days, your insurance has not remitted payment to us, payment will be due in full from you. Please keep in mind that not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover. If, at any time, you should want to avail yourself of our credit card payment system, we do accept VISA, MasterCard, or Discover, as mentioned above. Accounts over 60 days old will incur interest charges of 1.3%.

If you belong to a PPO, we follow the guidelines set forth in those plans. Please be sure to bring a referral form with you for your appointment if it is applicable. Services cannot be rendered if proper authorization has not been given. We do participate with Medicare, Blue Cross Blue Shield, United Health Care, Midlands Choice, Humana, Aetna/Coventry Health Care, and all Nebraska Medicaid plans.

We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account. We do use outside agencies as a means of collection should we deem it necessary.

By signing this, you agree that this office, and any third party used for treatment, billing, collection, and other services, may use any means of communication with you. Thus, you understand and agree that any phone numbers and e-mail addresses provided by yourself to this office and to any of our service providers, now and in the future, may be used as a means to contact you, and that this office and our service providers may leave messages for you manually and by using automated systems such as by artificial or prerecorded voice.

If you have any questions about the above information or an uncertainty regarding insurance coverage, do not hesitate to ask us. We are here to help you.

*Patient/Guarantor Signature*_____ *Date*_____

PATIENT CLINICAL INFORMATION

PLEASE INDICATE ANY OF THE FOLLOWING THAT PERTAIN TO YOUR MEDICAL HISTORY:

_____Alzheimer's	_____Ankle Swelling	_____Arthritis	_____Asthma
_____Blood Clots	_____Cancer	_____Diabetes	_____Difficulty Healing
_____Epilepsy	_____Gout	_____Heart Disease	_____High Blood Pressure
_____Kidney Disorders	_____Liver Disorders	_____Lung Disorders	_____Multiple Sclerosis
_____Neuropathy	_____Parkinson's Disease	_____Polio	_____Poor Circulation
_____Pregnant (currently)	_____Raynaud's Disease	_____Rheumatic Fever	_____Stroke
_____Tested positive HIV/AIDS	_____Thyroid Disorders	_____Tuberculosis	_____Ulcers

Any others not mentioned above:_____

PLEASE INDICATE IF YOU HAVE EVER EXPERIENCED ANY ADVERSE SIDE EFFECTS OR ALLERGIES TO:

____Penicillin	____Novocaine	____Sulfa Drugs	____Cortisone	____None
____Other Antibiotics	____Adhesive tape	____Aspirin	____Iodine	
____Codeine	____Latex	____Other Pain Medication	____Anti-inflammatory	

Allergy to any other Medications not listed above:_____

NAME OF FAMILY PHYSICIAN & THE LAST DATE YOU WERE SEEN: _____

ARE YOU PRESENTLY UNDER A PHYSICIAN'S CARE? ❑ Yes ❑ No IF YES, PLEASE EXPLAIN: _____

_____

WHAT MEDICATIONS ARE YOU PRESENTLY TAKING? (Including over-the-counter medication):

_____

_____

Do you take Aspirin daily? ❑ Yes ❑ No
Do you take a blood thinning medication for ex. Coumadin? ❑ Yes ❑ No
Do you have a condition that requires antibiotics before surgery/dental cleanings? ❑ Yes ❑ No

HAVE YOU HAD ANY SURGERY IN THE LAST 3 YEARS? ❑ Yes ❑ No IF YES, PLEASE EXPLAIN:_____

_____

DO YOU SMOKE? ❑ Yes ❑ No YEARS SMOKED: _____

FOOT HEALTH INFORMATION

What is your foot problem:_____
Please be as specific as possible

Date of injury, and/or when did you first notice symptoms? _____
How have you treated your problem so far? _____
Have you seen another doctor for this problem? ❑ Yes ❑ No If so, who? _____
Have you had an x-ray? ❑ Yes ❑ No If yes, where taken? _____
Have you had any cortisone injections? ❑ Yes ❑ No If yes, by whom? _____
Was this a work-related injury? ❑ Yes ❑ No If so, when and how did the injury occur?

_____