

Frisco Footcare At Stonebriar
Christopher A. Dobry, DPM - Podiatric Surgeon

3550 Parkwood Blvd. #G-703 • Frisco, Texas 75034
Main: (214) 618-3750 • Fax: (214) 618-3751 www.friscofootcare.com

Patient Registration

(Please fill out completely. All Information is Confidential and Required for our records)

Patient Information

Last Name: _____ First: _____ Middle: _____

Address: _____ Zip: _____

Patient SSN: _____ Age: _____ Birthdate: (DOB): _____

Patient Martial Status: (please circle) Married Single Divorced Separated Widowed Sex: (please circle) Female Male

Mobile Phone: _____ Home Phone: _____ Work Phone: _____

Patient Email Address: _____

Spouse Name: _____ Spouse Phone: _____

Responsible Party Name: _____ Relationship: _____

(If Patient Under 18 Years Old)

Responsible Party Address (If Different): _____

Emergency Contact: _____ Phone: _____ Relationship to Patient: _____

How did you hear about us? _____

Insurance Information

Primary Insurance Company: _____ **Claims Address:** _____

Member ID/Policy #: _____ Group #: _____

Insurance Phone: _____ Employer: _____ Employer Phone: _____

Policyholder Name: _____ Policyholder DOB: _____ Policyholder SSN: _____

Policyholder Phone: _____ Policyholder Relation to Patient: _____

Policyholder Address: _____

Secondary Insurance Company: _____ **Claims Address:** _____

(Medicare Only)

Member ID/Policy #: _____ Group #: _____

Insurance Phone: _____ Employer: _____ Employer Phone: _____

Policyholder Name: _____ Policyholder DOB: _____ Policyholder Phone: _____

Policyholder Relation to Patient: _____

Policyholder Address: _____

By signing below, I acknowledge that I have received or been offered a copy of the Health Information Privacy & Portability Act - Privacy Statement from Frisco Footcare at Stonebriar.

Please Note: In the case of services provided to patients under the age of 18, (minor) a parent, guardian, or legal representative must accompany the patient to the appointment and that person will be responsible for the payment of any co-pays, deductibles, and/or coinsurance. We will not bill other individuals who are not present for the appointment.

Printed Name of the Patient

Signature of Patient or Responsible Party if a Minor

Date

Frisco Footcare At Stonebriar
Christopher A. Dobry, DPM - Podiatric Surgeon

3550 Parkwood Blvd. #G-703 • Frisco, Texas 75034
Main: (214) 618-3750 • Fax: (214) 618-3751 www.friscofootcare.com

Patient Medical History

(Please fill out completely. All Information is Confidential and Required for our records)

Primary Care Physician: _____ Phone: _____ Fax: _____

Address: _____ Zip: _____

Was the Patient referred to our office: _____ By Whom: _____

Previous Podiatrist(s) Seen: _____ When: _____ Previous Problem: _____

State in your own words your medical reason(s) for coming to our office: _____

Approx. Shoe Size _____ Approx. Weight (Lbs) _____ Approx. Height (Ft/In) _____

Please list **all** the **medications** which the patient is currently taking (Prescribed and Over the Counter): _____

See List.

Please list **all** the medications to which the patient has an **allergic reaction** – Including the Reaction (Prescribed and Over the Counter): _____

See List.

Do you now or have you ever had any of the following problems:

Arthritis?	No _____ Yes _____	For how long: _____	Dr Treating: _____
Cancer?	No _____ Yes _____	For how long: _____	Dr Treating: _____
Stroke?	No _____ Yes _____	For how long: _____	Dr Treating: _____
Diabetes?	No _____ Yes _____	For how long: _____	Dr Treating: _____
Hepatitis?	No _____ Yes _____	For how long: _____	Dr Treating: _____
High Blood Pressure?	No _____ Yes _____	For how long: _____	Dr Treating: _____
Hyper/Hypothyroidism	No _____ Yes _____	For how long: _____	Dr Treating: _____
Kidney Disease?	No _____ Yes _____	For how long: _____	Dr Treating: _____
Heart Disease/Attack?	No _____ Yes _____	For how long: _____	Dr Treating: _____
Tuberculosis?	No _____ Yes _____	For how long: _____	Dr Treating: _____

Please list any **other medical problems** you now have or have had in the past: _____

See List.

Please list **all surgeries** and/or **hospitalizations** and their reason: _____

See List.

Patient Occupation: _____ For how long: _____ Requires Standing/Walking: _____

Are You? Single _____ Married _____ Divorced _____ Widowed _____

Do you have children? No _____ Yes _____ Number: _____ Age(s): _____

Do you smoke? No _____ Yes _____ Quit _____ For how long (ago): _____ Pack(s) per day: _____

Do you drink alcohol? No _____ Yes _____ Quit _____ For how long (ago): _____

Have any of **your relatives** (Parents, Siblings, Grandparents, etc.) had any of the following medical problems:

Arthritis?	No _____ Yes _____	Relationship: _____	Type: _____
Cancer?	No _____ Yes _____	Relationship: _____	Type: _____
Stroke?	No _____ Yes _____	Relationship: _____	Type: _____
Diabetes?	No _____ Yes _____	Relationship: _____	Type: _____
Hepatitis?	No _____ Yes _____	Relationship: _____	Type: _____
High Blood Pressure?	No _____ Yes _____	Relationship: _____	Type: _____
Thyroid Disease?	No _____ Yes _____	Relationship: _____	Type: _____
Kidney Disease?	No _____ Yes _____	Relationship: _____	Type: _____
Heart Disease/Attack?	No _____ Yes _____	Relationship: _____	Type: _____
Tuberculosis?	No _____ Yes _____	Relationship: _____	Type: _____

Patient Information Release Agreement

(Please Read Carefully and Sign Below)

I, _____, (Patient/Guardian) hereby authorize the staff of Frisco Footcare at Stonebriar, and Dr. Christopher Dobry to disclose information to the following person(s) about my procedures, as well as any other information concerning my health. I also authorize the following persons to receive information concerning my billing statement, and insurance records.

Name	Relationship
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____
5. _____	_____
6. _____	_____
7. _____	_____
8. _____	_____

Please note:

There will be times this office will call and leave messages regarding appointments and/or procedures. If this is unacceptable please indicate another way in which our office may contact you:

This will be effective until I, _____, (Patient/Guardian) put in writing that I withdraw the above listed persons.

Signature (Patient/Guardian)

Date

Office Payment Policies
Frisco Footcare At Stonebriar - Christopher A. Dobry, DPM

3550 Parkwood Blvd. #G-703 • Frisco, Texas 75034
Main: (214) 618-3750 • Fax: (214) 618-3751 www.friscofootcare.com

(Please Read all Policies)

At Frisco Footcare at Stonebriar, we are dedicated to providing you with the best medical care available. In order to do that, we will need your assistance in providing us with the necessary information. This information will be kept confidential as directed by law. We hope you understand that the information provided is used for purposes of providing services to you and is shared only with your insurance company and/or referring physician for the purpose of reimbursement.

Patient/Guardian Financial Responsibility:

- A current / valid insurance card and proof of identification (Drivers License) must be presented at the time of service in order for treatment to be rendered. Without both pieces of identification, appointments will be rescheduled for another time.
- We will file your insurance claim if we are a participating provider under the plan for which you are enrolled. Insurance benefits and possession of a health insurance card are not a guarantee of medical fee coverage. **Any out of pocket expenses, co-pays, deductibles or co-insurance are the responsibility of the patient and are due at the time of service.** Additionally, you will be responsible for any medical services deemed "non-covered," "coverage terminated," "pre-existing," or "non-covered member" by your insurance. If we are not a participating provider on the plan which you are enrolled, payment will be due at the time of service. Co-pays not collected at the time of service will be charged to the patient account. All fees so incurred are subject to collections.
- We accept cash, checks, debit cards, MasterCard, Visa, American Express, and Discover. If a check is used as payment, your driver's license must be provided. There will be a \$50.00 charge for all returned checks. All fees so incurred are subject to collections.
- We make every effort to remind patients of their appointment at least one day in advance. This is done as a courtesy only. The patient is ultimately responsible for remembering to keep their appointment. Two (2) missed/No Show office appointments will result in a fee of \$100.00. One (1) missed/No Show hospital surgery will result in a fee of \$500.00 and refusal of further treatment and immediate discharge from care. All fees so incurred are subject to collections.
- A fee of \$50.00 will be assessed for completion of any personal disability forms, personal credit life insurance forms, personal attending physician statements, or other miscellaneous forms, including direct phone calls from this office to the requesting entity. This is time-consuming labor for the physician/staff not included in the cost of the surgery/treatment and therefore must be absorbed by the patient/guardian. Additional fees may be added for additional forms/work. All fees so incurred are subject to collections.
- In the case of services provided to patients under the age of 18, (minor) a parent/guardian, or legal representative must accompany the patient to the appointment and that person is responsible for the payment of any co-pays, deductibles, and/or coinsurance. We will not bill other individuals nor estranged spouses who are not present at the appointment. All fees so incurred are subject to collections.

Medicare Patients/Guardians:

- Medicare **DOES NOT** cover the costs for routine trimming of corns, calluses, or toenails unless you are a diabetic with documented evidence of neuropathy and/or circulation impairment, or have multiple sclerosis, atherosclerosis, or peripheral vascular disease and are under the active care of a physician for that disease. The name, address, and phone number of the primary care physician treating the patient will be required for these services. Please see www.cms.hhs.gov for specific information regarding the benefits for routine care services. Payment for non-covered routine care (\$40.00) is expected at the time of service. All fees so incurred are subject to collections.

Please read carefully and initial below:

- Insurance benefits and possession of a health insurance card are not a guarantee of medical fee coverage. Your health insurance policy is a contract between (a) you, your employer, and the insurance company or (b) you and the insurance company, alone. It is the responsibility of the patient/guardian to be aware of and understand the details of their insurance plan. **Ultimately, all medical charges are the responsibility of the patient/guardian.** All fees so incurred are subject to collections.

Initials _____

- Regretfully, we cannot always be aware of the particular details of each insurance plan. No guarantee of health insurance benefits may be established from any insurance carrier. Therefore, it is the responsibility of the patient/guardian to be aware of any exclusions and/or provisions with the plan. We file your health insurance claims as a courtesy only. Any billed charges not covered by the insurance explanation of benefits (EOB) from a processed claim will be the patient/guardian's responsibility. All fees so incurred are subject to collections.

Initials _____

- It is the responsibility of the patient/guardian to inform our office if your insurance has changed. Each insurance company has a deadline for filing claims. If you have not informed us of an insurance company change, and we exceed the deadline for receiving payment because we had been billing the wrong insurance company, then the patient/guardian will be responsible for full payment of the denied claim(s). Medical charges billed to old or inactive insurance policies may result in additional fees to the patient. All fees so incurred are subject to collections.

Initials _____

By signing below, I testify that I have read and understand the above policies and acknowledge that I am responsible for payment of the account. Furthermore, I hereby agree that any pictures, memoranda, illustrations, or other medical information related to my treatment may be utilized by Dr. Christopher Dobry in a professional capacity.

Printed Name of the Patient

Signature of Patient/Guardian

Date