

**Dr. Margaret A Withrow, DPM**  
**13660 N 94<sup>th</sup> Drive Suite A-3**  
**Peoria, Arizona 85381**  
**Phone 623-933-4645 Fax 623-933-4677**

Patient's Name: \_\_\_\_\_

Patient's Social Security #: \_\_\_\_\_

Patient's Address (local) \_\_\_\_\_

Birthdate \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Age: \_\_\_\_

City, State and Zip \_\_\_\_\_

Sex: M F Marital Status: S M W Other

Phone # (local) \_\_\_\_\_

Spouse Name \_\_\_\_\_

Cell Ph # \_\_\_\_\_ Work # \_\_\_\_\_

Relative/Friend Not Living in home \_\_\_\_\_

Responsible Party \_\_\_\_\_

Phone # \_\_\_\_\_

Responsible Party Phone # \_\_\_\_\_

Primary Care Physician \_\_\_\_\_

Responsible Party Phone # \_\_\_\_\_

Primary Care Physician # \_\_\_\_\_

Preferred Language \_\_\_\_\_

Referred by \_\_\_\_\_

Race \_\_\_\_\_

\* These are government categories. If you need help please ask.

Ethnic Group \_\_\_\_\_

**EMPLOYMENT INFORMATION**

Patient/Parent Occupation \_\_\_\_\_

Patient/Parent Employer \_\_\_\_\_

Spouse's Employer \_\_\_\_\_

Employer Address \_\_\_\_\_

Employer Address \_\_\_\_\_

City, State and Zip \_\_\_\_\_

City, State and Zip \_\_\_\_\_

**INSURANCE INFORMATION – We will copy your insurance card but we need you to fill out this section!**

Primary Insurance \_\_\_\_\_

Secondary Insurance \_\_\_\_\_

Ins Co Phone # \_\_\_\_\_

Ins Co Phone # \_\_\_\_\_

Ins Co Address \_\_\_\_\_

Ins Co Address \_\_\_\_\_

Policy Holder Name/ Date of Birth \_\_\_\_\_

Policy Holder Name/Date of Birth \_\_\_\_\_

ID # \_\_\_\_\_

ID # \_\_\_\_\_

**PHARMACY INFORMATION**

Name \_\_\_\_\_

Phone # \_\_\_\_\_

**MEDICAL HISTORY**

Name \_\_\_\_\_ Date \_\_\_\_\_

Height \_\_\_\_\_ Weight \_\_\_\_\_ Shoe Size \_\_\_\_\_

What type of foot problems bring you to our office? \_\_\_\_\_

**PAST MEDICAL HISTORY**

Please circle if you have any of the following:

Diabetes Heart attack High Blood Pressure Bad Circulation to the feet Raynaud's COPD/Emphysema

Asthma Stroke Seizures Kidney Disease Liver Disease Stomach Ulcers Thyroid Disease Cancer

Arthritis/Osteoarthritis Rheumatoid Arthritis Gout Swelling ankles /feet or

Other \_\_\_\_\_

Regular Medications (including Aspirin) Dosage or attach list

\_\_\_\_\_  
\_\_\_\_\_

Previous Surgeries (Type and Date) \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

**ALLERGIES**

Please circle if you have any of the following:

Penicillin Aspirin Codeine Sulfa Novocain Iodine Shellfish Adhesive Latex

Other, please specify: \_\_\_\_\_

**SOCIAL HISTORY**

Do you smoke? Yes or No Number of pack(s) per day? \_\_\_\_\_ Have you ever smoked? Yes or NO

Do you drink? Yes or No How many ounces per week? \_\_\_\_\_

Do you Exercise? Yes or No

Occupation \_\_\_\_\_

How did you hear about us? \_\_\_\_\_

**FAMILY HISTORY**

Do you have family history of (please circle any that apply)

Diabetes Heart Disease Blood Clots Bleeding Problems Gout Rheumatoid Arthritis Hypertension

**Please circle all that apply:**

**NEURO:** tingling numbness burning sciatica pins and needles NONE  
Other:

**PSYCHIATRIC:** depression anxiety stress bipolar dementia NONE  
Other:

**EYES:** visual problem blurry vision macular degeneration NONE  
Other:

**NOSE:** nasal allergies nose bleeds NONE  
Other:

**THROAT:** swallowing difficulty frequent sore throats speech problems NONE  
Other:

**MOUTH:** dental problems tongue problems canker sores NONE  
Other:

**NECK:** swollen glands thyroid problems NONE  
Other:

**CHEST:** chest pain asthma shortness of breath cough TB NONE  
Other:

**HEART:** murmurs palpitations valve problems angina NONE  
Other:

**VASCULAR:** swollen legs varicose veins cramps when walking cold legs/feet-rest pain NONE  
Other:

**INTESTINAL:** colitis ulcer gastritis Barrett's esophagus polyps constipation NONE  
Other:

**URINARY:** urinary problems urinary frequency burning kidney stones NONE  
Other:

**GENITOURINARY:** urinary problems urinary frequency burning kidney stones yeast infections NONE  
Other:

**SPINE:** low back pain neck pain mid back pain scoliosis herniated disc NONE  
Other:

**SKIN:** rashes thick nails itching skin cancer NONE  
Other:

**SYSTEMIC:** weigh loss fever night sweats trouble sleeping loss of energy NONE  
anemia bruise easily  
Other:

**MUSCULOSKELETAL:** joint pain joint swelling joint stiffness gout R.A>

PATIENT SIGNATURE AND DATE \_\_\_\_\_

DPM Reviewed, sign and date \_\_\_\_\_

**RELEASE OF INFORMATION/INSURANCE ASSIGNMENT**

**DO WE HAVE PERMISSION TO:**

Leave a message on your answering machine at home? \_\_\_\_\_ Yes \_\_\_\_\_ No  
Leave a message at your place of employment? \_\_\_\_\_ Yes \_\_\_\_\_ No  
Discuss your medical condition with any member of your household? \_\_\_\_\_ Yes \_\_\_\_\_ No

If YES, with whom? \_\_\_\_\_

I authorize the release of any medical information necessary to process claims for services I have been provided. I permit a copy of this authorization to be used in place of the original. I authorize Margaret Withrow, DPM, PC to apply for benefits on my behalf for any covered services. I request that payment from the insurance company be made directly to Margaret Withrow, DPM, PC. I authorize Margaret Withrow, DPM, PC to contact and forward any pertinent medical information to my other physician for their records. I further understand that I am responsible for all charges whether or not they are paid by my insurance company. I certify that the above information is correct.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Acknowledgement of Notice of Privacy Practices**

I hereby acknowledge that I have received Margaret A. Withrow, D.P.M. Notice of Privacy Practices. (Copies are available at the front desk)

\_\_\_\_\_  
Signature of patient or patient representative Date

**FOR OFFICE USE ONLY**

**Documentation of Good Faith Efforts**

**To obtain patient's acknowledgement that they received provider's Notice of Privacy Practices**

*(For use when acknowledgement cannot be obtained from patient)*

The patient presented to the office and was provided with a copy of Covered Entity's notice of Privacy Practices. A good faith effort was made to obtain from the patient a written acknowledgement of his/her receipt of the Notice. However, such acknowledgement was not obtained because:

- Patient refused to sign
- Patient was unable to sign or initial because: \_\_\_\_\_
  
- The patient had a medical emergency, and an attempt to obtain the acknowledgement will be made at the next available opportunity.
- Other reason (describe): \_\_\_\_\_

\_\_\_\_\_  
Signature of Employee Completing Form Date

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**NO SHOWS AND LATE CANCELLATIONS POLICY**

In an effort to serve our patients and the community well, we must utilize our time efficiently. When a patient makes an appointment, time is set aside for their needs, and work is performed to prepare their record for the visit. When a scheduled visit is not completed, there is a loss for another patient who could have used that available time, as well as wasted staff time. Therefore, we ask that when a scheduled visit cannot be met, it be cancelled at least twenty-four hours prior to the time of the appointment. For late cancellations or not showing for a scheduled appointment, a \$50 fee will be charged.

I acknowledge receipt of this policy and agree to make payment for the amount of \$50 in the event that I cancel an appointment without appropriate notice or neglect to show up for a scheduled appointment.

Signature of patient/responsible party: \_\_\_\_\_ Date: \_\_\_\_\_

**FINANCIAL POLICY**

Thank you for choosing us as your health care provider. We strive to provide the most up to date and cost effective treatment, therapy and products for your foot and ankle care. Please understand that payment of your bill is considered a part of your treatment.

Medicare patients are required to meet a \$162.00 calendar year deductible. If you have a supplemental or secondary insurance please inform our staff prior to your visit.

**Non-covered medical supplies or services must be paid in full at the time of the visit.**

Indemnity insurance plans such as Blue Cross/Blue Shield will be billed. You will be responsible for any co-insurance and deductible amounts. If we do not receive payment within 90 days, we will transfer the balance to your responsibility for payment.

Patients who are covered by a commercial insurance carrier, with whom we are not participating with, will remain responsible for their balance. We will courtesy bill your carrier. If we do not receive payment within 90 days, we will transfer the balance to your responsibility for payment.

Patients that do not have medical insurance will be required to pay for the services rendered in full on the date of service. We will try to accommodate patients by supplying an estimate prior to seeing the doctor. Payment plans are not accepted.

We require payment in the form of cash, money order, check or Visa/Master Care/Discover.

Thank you for understanding our Financial Policy. Please let us know if you have questions or concerns.

Copays and balances are due at the time of service.

There will be a \$5.00 billing fee for copays not paid on the date of service.

For balances not paid in full within 30 days of the initial statement, there will be a \$5.00 rebilling fee for each additional monthly statement that is sent out.

I have read the Financial Policy. I understand and agree to this Financial Policy.

\_\_\_\_\_  
Signature of Patient/Responsible Party

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Witness

\_\_\_\_\_  
Date