Bay Area Foot Clinics

THOMAS R. KOMP, D.P.M.
Diplomate,
American Board of
Podiatric Surgery

Thank you for choosing Bay Area Foot Clinic for your comprehensive foot care needs. Enclosed you will find registration forms that we would like completed when you come in for your initial office visit. Also,bring any insurance cards or forms that you would like us to file for you.

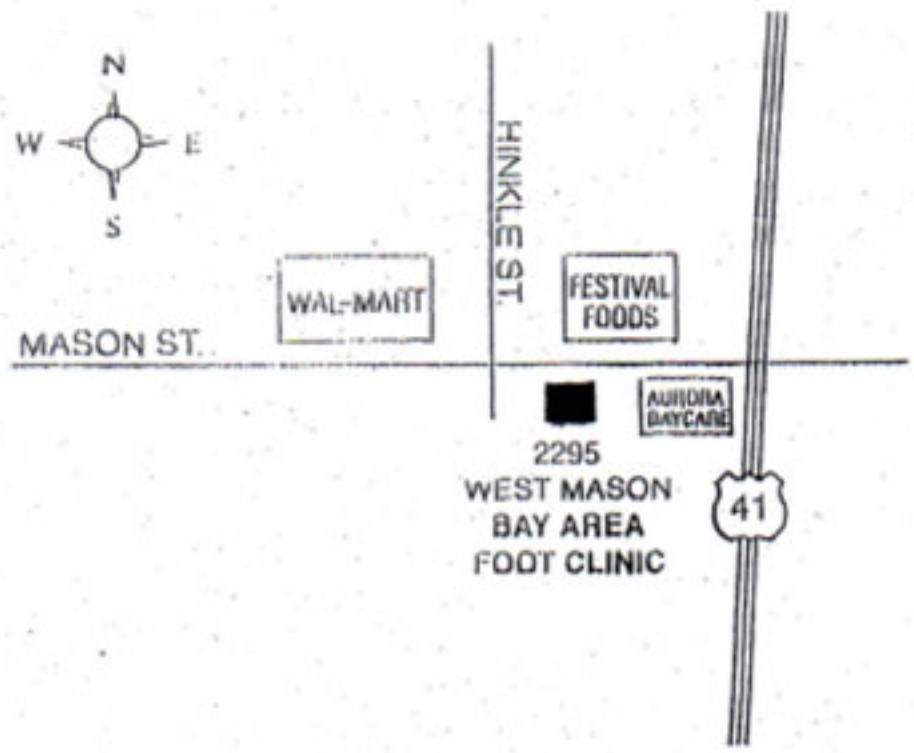
Your appointment has been scheduled with Dr Komp on:

DAY_____

DATE_____

TIME_____

Please contact us 24 hours in advance if you are unable to make this appointment at 920-498-2226 or 800-924-1515.



2295 W. MASON STREET • GREEN BAY • WI 54303
(920) 498-2226 • 1-800-924-1515

PATIENT REGISTRATION

FIRST NAME	M.I.	LAST NAME	SOCIAL SECURITY NUMBER

STREET ADDRESS	CITY	STATE	ZIP

HOME PHONE ( ) -	WORK PHONE & EXTENSION ( ) -	DATE OF BIRTH	AGE

SEX ❑ Male ❑ Female	MARITAL STATUS ❑ Single ❑ Married ❑ Divorced ❑ Widowed	EMERGENCY CONTACT NAME	EMERGENCY CONTACT PHONE

HOW DID YOU HEAR ABOUT OUR OFFICE?

REFERRING PHYSICIAN	PRIMARY PHYSICIAN

EMPLOYER

EMPLOYER NAME	PHONE

STREET ADDRESS	CITY	STATE	ZIP

OCCUPATION	STUDENT STATUS ❑ FULL TIME ❑ PART TIME

PRIMARY INSURANCE

INSURANCE COMPANY NAME	RELATION TO SUBSCRIBER	COPAY

SUBSCRIBER'S NAME	SUBSCRIBER'S EMPLOYER

SUBSCRIBER'S DATE OF BIRTH	SUBSCRIBER'S SEX ❑ Male ❑ Female	SUBSCRIBER'S ID#	GROUP NUMBER

SECONDARY INSURANCE

INSURANCE COMPANY NAME	RELATION TO SUBSCRIBER	COPAY

SUBSCRIBER'S NAME	SUBSCRIBER'S EMPLOYER

SUBSCRIBER'S DATE OF BIRTH	SUBSCRIBER'S SEX ❑ Male ❑ Female	SUBSCRIBER'S ID#	GROUP NUMBER

RESPONSIBLE PARTY: WHO IS RESPONSIBLE FOR THE REMAINING BALANCE ON THIS ACCOUNT?

❑ Self (1)
❑ Spouse (2)
❑ Parent (3)
❑ Legal Guardian (4)

SOCIAL SECURITY NUMBER	LAST NAME	FIRST NAME	M.I.

STREET ADDRESS	CITY	STATE	ZIP

HOME PHONE	WORK PHONE	WORK EXT.	DATE OF BIRTH	SEX ❑ Male ❑ Female

I CERTIFY THAT THE INFORMATION ON THIS FORM IS TRUE TO THE BEST OF MY KNOWLEDGE. I ACCEPT RESPONSIBILITY FOR THE MEDICAL CHARGES INCURRED BY THE PATIENT AND AGREE TO PAY BILLS AT TIME OF SERVICE UNLESS OTHER ARRANGEMENTS ARE MADE. I AUTHORIZE PHYSICIAN AND CLINIC TO RELEASE ANY INFORMATION TO PROCESS INSURANCE CLAIMS. I ALSO AUTHORIZE MY INSURANCE CLAIM TO BE PAID DIRECTLY TO THE CLINIC. I FURTHER UNDERSTAND THAT MY HEALTH CARE INSURANCE CARRIER OR PAYOR OF MY HEALTH BENEFITS MAY PAY LESS THAN THE ACTUAL BILL FOR SERVICES, AND THAT ALL SECOND OPINION AND PREADMISSION REVIEW REQUIREMENTS ARE ULTIMATELY MY RESPONSIBILITY.

SIGNATURE _____ DATE _____

PODIATRIC HISTORY

What is the chief complaint for which you came to be treated?

_____

_____

_____

Have you ever been to a Podiatrist before? ❑ Yes ❑ No
If yes, please list.

Name _____

Last visit _____

PATIENT'S MEDICAL STATUS

	YES	NO
DIABETES	❑	❑
HIGH BLOOD PRESSURE	❑	❑
HEART DISEASE	❑	❑
ARTHRITIS	❑	❑
DRUG REACTIONS	❑	❑
ASTHMA	❑	❑
ANEMIA	❑	❑
HAY FEVER	❑	❑

ALLERGIES

	YES	NO
PENICILLIN	❑	❑
ASPIRIN	❑	❑
CODEINE	❑	❑
ADHESIVE TAPE	❑	❑
ANESTHETIC	❑	❑

OTHER _____

OUR FINANCIAL POLICY

Thank you for choosing us as one of your health care providers. We are committed to your treatment being successful. The following is a statement of our Financial Policy which we require you read and sign prior to any treatment. All patients are required to complete our Information and Insurance Form before seeing the doctor.

Regarding Insurance:

Your insurance policy is a contract between you and your insurance company, we are not a party to that contract. Please be aware that some, and perhaps all, of the services provided maybe non covered services and not considered reasonable by your insurance policy. After we receive your insurance payment you will be billed for the portion your insurance does not cover. Full payment will be expected within 45 days for the remaining balance. **We submit insurance claims as a courtesy to our patients.**.

Regarding Insurance Plans where we are a participating provider: All co-pays and deductibles are due at the time of treatment.

We cannot bill your insurance company if you do not give us current and accurate insurance information. Please keep our office advised of all changes in regard to your insurance coverage as well as personal information needed to keep our record's current.

*** **Usual and Customary fees**

Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payments regardless of any insurance company's determination of usual and customary fees.

*** **Adult patients**

Adult patients are responsible for the payment of charges incurred.

*** **Minor patients**

The adults accompanying a minor or the parents of a minor are responsible for any charges incurred. For unaccompanied minors, non emergency treatment can be denied.

*** **Missed appointments**

Unless canceled, at least 24 hours in advance, our policy is to charge for missed appointments at a rate of a normal office visit. Please help us serve you better by keeping scheduled appointments.

***** I have read, understand and agree to this Financial Policy. *****

X_____ date _____

the signature of patient/responsible party

We accept credit cards, cash and checks. Payment plans can be arranged with prior approval from our accounting firm.

NAME _____ DATE _____

HISTORY AND PHYSICAL FORM

HISTORY

Chief Complaint and History of Present Illness:

_____

_____

_____

_____

HEIGHT WEIGHT SHOE SIZE

Past Medical History: Family Physician: _____

( ) diabetes ( ) hypertension ( ) nervous conditions
( ) stroke ( ) arthritis ( ) skin problems
( ) rheumatic fever ( ) heart disease ( ) other/explain:
( ) seizure disorders ( ) hepatitis
( ) bleeding disorders ( ) sickle cell anemia ( ) cancer/explain:

Past Surgical History:

Hospitalization/Surgeries	Date	Hospitalization/Surgeries	Date

Allergies:

( ) penicillin ( ) codeine ( ) aspirin ( ) tape
( ) local anesthetic ( ) food ( ) clothing ( ) iodine
( ) sulphur ( ) sulfates ( ) other/explain:

Medications:

Name	Illness	Physician	Name	Illness	Physician

Family History:

( ) diabetes ( ) hypertension ( ) cancer ( ) heart disease

Social History:

Occupation _____ Tobacco (pkg/day) _____
Coffee (cups/day) _____ Alcohol _____

Review of Systems:

HEENT _____ Genitourinary _____
Respiratory _____ Neuropsychiatric _____
Cardiovascular _____ Locomotor _____
Gastrointestinal _____
Other/explain _____

Misc. Notes:

Key: (+) = present (–) = not present