Clintonville Foot & Ankle Group

With offices in Clintonville, Dublin and Southwest Columbus

***Corey J. Griffith, DPM, FACFAS**
***Randall C. Thomas Jr., DPM, FACFAS**

*Board Certified Foot and Ankle Surgeons

Clintonville
3695 N. High St.
Columbus, OH 43214
P: (614) 267-8387
F: (614) 267-2250

Dublin
6850 Perimeter Dr. Suite B
Dublin, OH 43016
P: (614) 761-1466
F: (614) 761-1809

Southwest
2350 Briggs Rd.
Columbus, OH 43223
P: (614) 272-2313
F: (614) 272-2637

To our new patients: Welcome to our practice! We understand that you have a lot of options for your healthcare and we appreciate you choosing us to help you get back on your feet.

To our established patients: Welcome Back! We appreciate your continued confidence in our practice.

Office Policies:

- If you are unable to keep your appointment, we ask that you notify us 24 hours in advance. You can leave a message after hours on our voicemail. Failure to provide adequate notice may result in a $40 fee.
- If you are running late for an appointment, please call the office. If you don't call ahead and are more than 15 minutes late, your appointment may need to be rescheduled.
- We will file a claim with your insurance on your behalf, so we ask that you let us know of any changes that may occur in your coverage. Please bring your insurance card to every appointment.
- All copayments are due at the time of your visit. Any outstanding balance on your account, from either your deductible and/or coinsurance is also due at the time of your visit unless you have made other arrangements with our billing department.
- We accept all major credit cards and checks. Cash is accepted, however we do not keep change in the office, so any change due will be credited to your account.

If you have any questions about our office polices, please don't hesitate to ask.

I recognize that some services offered by Clintonville Foot and Ankle Group are not eligible for insurance submission. I acknowledge that performance of these services, at my discretion, will be my financial responsibility.

I acknowledge that I have read, understand, and will abide by the above policies.

Signature_____ **Date**_____

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Name:_____ DOB:_____ Date:_____

Current Medications: Name	Dose: (ex: mg/ml)	Route: (oral)	Frequency: (how often)

Drug Allergies: _____

Other Allergies: _____

Pharmacy (name/street):_____

Height:_____ Weight:_____ Shoe Size:_____

Diabetes: No_____ Type I _____ Type II _____ When were you diagnosed? _____

Personal Medical History: (Please circle all that apply)

Congestive Heart Failure	Osteoarthritis	GI Bleed	Hypothyroidism
Blood Clots	Gout	Stomach/ Bowel Problems	Hyperthyroidism
High Blood Pressure	Rheumatoid Arthritis	Kidney Disease/ Dialysis	Autism
Heart Attack	Psoriatic Arthritis	HIV/ AIDS	Cystic Fibrosis
Stroke / TIA	Alzheimer's	Hepatitis ___A___B___C	Depression / Suicidal thoughts
Pacemaker / Defibrillator	Seizures	Asthma	Alcohol / Drug Addiction
Irregular Heart Beat	Aneurysm	Emphysema	Anemia
Cancer	Pulmonary Embolism	Sleep Apnea	Fibromyalgia
Bleed/ Bruise Easily	COPD	Mental Illness	Other_____

Surgical History: (Please list procedure and the year it was preformed)

_____

_____

_____

Name: _____ DOB: _____ Date: _____

Family History: M (Mother)/ F (Father)

M / F Anesthesia Problems	M / F Heart Problems
M / F Arthritis	M / F Neurological Disorder
M / F Cancer	M / F Respiratory Disorder
M / F Diabetes	M / F Seizures

Yearly Health Maintenance: Circle the ones that you have had performed in the **last 12 months**

Flu Vaccine	Colonoscopy (50+)	Pneumonia Vaccine (75+)	Woman (23+) Pap Smear	Woman (40+) Mammogram	Men(40+) Prostate Exam	Diabetic Retinal Eye Exam

Do you drink alcohol? Yes/ No How much: _____ per: Day / Week / Month

Do you smoke? Yes/ No/ Former How many per day? _____ For how long? _____ Quit date? _____

Occupation: _____

What is the main reason for seeing one of our physicians today? _____

Duration of Pain? _____ Is this related to an injury? Yes/ No

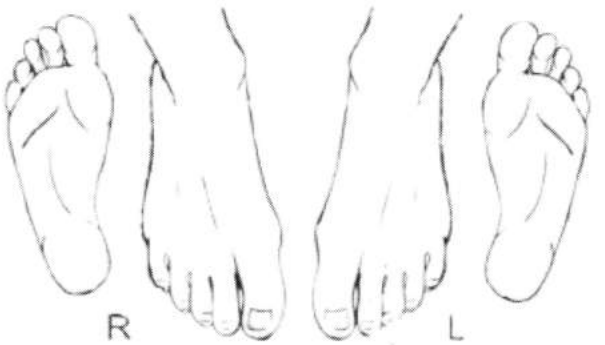
If yes, please describe: _____

Symptoms: _____

Please circle the treatments you have tried:

Custom Orthotics/ OTC Inserts	Braces	Seeing/Seen another Doctor
Physical Therapy	Injections	No Treatment
Anti- inflammatory Medications	Prior Surgery	Other Treatment _____

Please mark on the diagram where you are experiencing pain and/or symptoms:



Please Read and Sign

The above information is correct to the best of my knowledge. I understand that I am responsible for any charges incurred during any visit or Treatment by the doctors and staff of Clintonville Foot & Ankle Group. A fee schedule can be obtained upon request. I understand that payment is due at time of service with no insurance or for non-covered services.

_____ _____

Patient or Parent/Guardian Signature Date

Rev 2.20

PATIENT INFORMATION

PATIENT INFORMATION (PLEASE PRINT) **DATE**_____

LEGAL NAME_____
FIRST MI LAST

BIRTH DATE _____ AGE _____ MALE _____ FEMALE _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

HOME # _____ CELL # _____ WORK# _____

WHAT IS THE BEST NUMBER TO CONTACT YOU DURING THE DAY? HOME ____ CELL ____ WORK ____

MARITAL STATUS: MARRIED ____ SINGLE ____ DIVORCED ____ WIDOWED ____ OTHER ____

RACE: _____ HISPANIC? YES / NO LANGUAGE _____

SOCIAL SECURITY # _____ E-MAIL ADDRESS _____

HOW DID YOU HEAR ABOUT OUR OFFICE? _____

FAMILY DOCTOR _____ PHONE _____

EMERGENCY CONTACT _____ RELATIONSHIP _____

HOME PHONE (____) _____ CELL PHONE _____

PATIENT'S EMPLOYER

RETIRED? YES / NO STUDENT? FULL TIME / PART-TIME / NO

EMPLOYER _____ JOB TITLE _____

HEALTH INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY _____

POLICY HOLDER NAME _____ POLICY HOLDER BIRTH DATE _____

SECONDARY HEALTH INSURANCE (IF APPLICABLE)

SECONDARY INSURANCE COMPANY _____

POLICY HOLDER NAME _____ POLICY HOLDER BIRTH DATE _____

PHARMACY

PHARMACY NAME _____

PHONE _____

ADDRESS _____

WORKERS COMP INFORMATION

IS THIS A WORK RELATED ACCIDENT? YES / NO IF YES, DATE OF INJURY _____

IF YES, CLAIM NUMBER _____

AUTO/PERSONAL RELATED ACCIDENT? YES / NO

IF ACCIDENT, RESPONSIBLE PARTY: _____

NAME: _____

ADDRESS: _____

CITY _____ **STATE** _____ **ZIP** _____

CONTACT PERSON: _____

HIPPA COMPLIANCE

May we mail correspondence to your home address? Yes / No

May we leave detailed messages at your home number ? Yes / No

May we leave detailed messages at your work number? Yes / No / Not applicable

I CERTIFY THE INFORMATION PROVIDED ON THIS FORM IS CORRECT TO THE BEST OF MY KNOWLEDGE. I ALSO UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT COVERED BY INSURANCE. I AGREE TO BE HELD RESPONSIBLE FOR COLLECTION PROCESSING FEES, WHICH MAY BE ADDED TO MY ACCOUNT IN COLLECTION ACTION OCCURS. I AUTHORIZE THE RELEASE OF MEDICAL INFORMATION NECESSARY TO PROCESS CLAIMS. I AUTHORIZE THE RELEASE OF MEDICAL INFORMATION TO MY PRIMARY CARE PHYSICIAN AND TO ANY OUTSIDE FACILITY THAT IS ASSISTING WITH MY CARE, SUCH AS PHYSICAL THERAPY AND MRI FACILITIES.

I CERTIFY THAT I HAVE BEEN GIVEN THE OPPORTUNITY TO REVIEW THE REGULATIONS ON PATIENT PRIVACY LAWS IN THE FORM OF THE HIPPA OUTLINE PROVIDED BY MY PHYSICIAN.

SIGNATURE_____ DATE _____
IF MINOR, PARENT OR GUARDIAN PLEASE SIGN

For practice use only

Practice: Accepts Declines

Privacy Officer Signature: _____

Date: _____

REVISED 10/2014