GALLAGHER PODIATRY
KEVIN F. GALLAGHER, D.P.M.

3515 WASHINGTON ROAD
McMURRAY, PA 15317

PHONE: 724-941-4330
FAX: 724-941-4453

CONFIDENTIAL PATIENT INFORMATION

Patient Name: _____ Today's Date_____
First Middle Last

Home Address: _____

City: _____ State: _____ Zip: _____

Telephone: (____) _____ Cell Phone Number: (____) _____

Birthdate: _____ Age: _____ Social Security Number: _____

Driver's License Number: _____ Occupation: _____

Employer: _____ Employer's Telephone: (____) _____

Employer Address: _____ City: _____ State: ___ Zip: _____

E-mail Address: _____

Name of Spouse: _____ Social Security Number: _____

Birthdate: _____ Occupation: _____ Employer: _____

Employer's Address: _____ City: _____ State: _____

Zip: _____ Employer's Phone: (____) _____

Guarantor Section

Complete this section only if someone other than the patient is financially responsible. If the patient is a minor, the responsible party is the parent who accompanies the child to our office

Responsible Party: _____ Relationship to the Patient: _____

Home Address: _____

City: _____ State: _____ Zip: _____

Telephone: (____) _____ Cell Phone Number: (____) _____

Birthdate: _____ Age: _____ Social Security Number: _____

Driver's License Number: _____ Occupation: _____

Employer: _____ Employer's Telephone: (____) _____

Employer Address: _____ City: _____ State: ___ Zip: _____

E-mail Address: _____

Please list the name of the person to contact in case of emergency other than spouse or parent:

Name: _____ Relationship: _____

Home Phone: (____) _____ Work Phone: (____) _____

Name and address of primary care physician _____

GALLAGHER PODIATRY
MEDICAL HISTORY

Please describe your foot problem: _____

_____

Have you had any previous foot care or foot surgery? _____ Name of Doctor: _____
When were you last treated by him/her? _____

Height _____ Weight _____ Age _____ Shoe Size _____
Are you under a doctor's care at the present time? _____
How often do you use Alcohol? _____ How often do you use Nicotine? _____

Please check any of the following for which you or a blood relative have been or are being treated.

	SELF	RELATIVE		SELF	RELATIVE
Diabetes	____	____	Gout	____	____
Hypertension (High Blood Pressure)	____	____	Glaucoma/Eye	____	____
Cerebral Accidents (Stroke)	____	____	Thyroid (Hypo or Hyper)	____	____
Cardiac Disease	____	____	Epilepsy	____	____
Circulation (PVD)	____	____	Polio, Cerebral Palsy	____	____
Phlebitis/Thrombo	____	____	Muscular Dystrophy	____	____
Scarlet Fever	____	____	Neurological Disease	____	____
Rheumatic Fever	____	____	Gastro-Intestinal Disorders	____	____
Hemophilia (Bleeder)	____	____	Cancer	____	____
Anemia	____	____	Renal Disease	____	____
Asthma	____	____	Liver Disease (Hepatitis)	____	____
Emphysema	____	____	Tuberculosis	____	____
Sexually Transmitted Diseases	____	____	AIDS	____	____
Arthritis	____	____	Other-Please State: _____		

ALLERGIES: Are you allergic to any of the below? Please check.

____ Penicillin ____ Tetracycline ____ Aspirin ____ Sulfa Drugs ____ Novacaine
____ Codeine ____ Barbituates ____ Cortisone ____ Iodine Dyes ____ Foods
____ Adhesive Tape ____ Environmental ____ Caffeine ____ Other _____

Are you taking any medications? _____
If yes, please list: (Please include Vitamins or Birth Control Pills)

1. _____ 2. _____ 3. _____
4. _____ 5. _____ 6. _____
7. _____ 8. _____ 9. _____
10. _____ 11. _____ 12. _____

Have you had any previous surgery or hospitalization? (Include Fractures/Dislocations)
Yes ____ No ____ Please List: _____

_____

The information provided is correct to the best of my knowledge and I consent to such diagnostic procedures (including x-rays) and medical care and treatment as deemed necessary.

Date: _____ X _____ _____
Signature of Patient or Guarantor Witness

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Insurance Information

Primary

Name and Address of Insurance Company: _____

City: _____ State: _____ Zip: _____

Policy Holder's Name: _____ Policy Holder's Birthdate: _____

Policy Holder's Address: _____

City: _____ State: _____ Zip: _____

Policy Holder's Employer: _____

Policy ID Number: _____ Group Number: _____

Effective Date: _____ Insurance Company Phone Number: _____

Secondary

Name and Address of Insurance Company: _____

City: _____ State: _____ Zip: _____

Policy Holder's Name: _____ Policy Holder's Birthdate: _____

Policy Holder's Address: _____

City: _____ State: _____ Zip: _____

Policy Holder's Employer: _____

Policy ID Number: _____ Group Number: _____

Effective Date: _____ Insurance Company Phone Number: _____

Signature of Patient or Guarantor: _____ Date: _____

Witness: _____

GALLAGHER PODIATRY
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Patient Consent For Use and Disclosure of Protected Health Information

I hereby give my consent for Gallagher Podiatry to use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). (Gallagher Podiatry's Notice of Privacy Practices provides a more complete description of such uses and disclosures.)

I have the right to review the Notice of Privacy Practices prior to signing this consent. Gallagher Podiatry reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Gallagher Podiatry Privacy Officer at 3515 Washington Road, McMurray, PA 15317.

With this consent, Gallagher Podiatry may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory results among others.

With this consent, Gallagher Podiatry may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards, thank you postcards and patient statements as long as they are marked Personal and Confidential.

With this consent, Gallagher Podiatry may e-mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that Gallagher Podiatry restrict how it uses or discloses my PHI to carry out TPO.

However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement. By signing this form, I am consenting to Gallagher Podiatry's use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Gallagher Podiatry may decline to provide treatment to me.

Signature of Patient or Legal Guardian	Date	Witness

Assignment of Benefits

I hereby assign all medical and/or surgical benefits, to include major medical and comprehensive benefits to which I am entitled, including Medicare, Blue Cross-Blue Shield of PA, private insurance, and any other health plan to Gallagher Podiatry for any services furnished to me by them.

This assignment will remain in effect until revoking by me in writing. A photocopy of this assignment is to be considered valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize assignee to release all information to secure payment.

Signature of Patient or Legal Guardian	Date	Witness

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REQUEST FOR CONFIDENTIAL COMMUNICATIONS

NAME OF PATIENT: _____

DATE OF BIRTH: _____

I request that all communications to me (by telephone, mail or otherwise by Gallagher Podiatry and /or its staff be handled in the following manner:

- For oral communications: Call: _____ (telephone number)
- For written communications: Address to: _____
- May we leave a message on answering machine?

Yes☐ No☐

Are there any other person/persons that we may speak to about your health care information.

_____	_____	_____
(Name)	(Relationship)	(Phone)
_____	_____	_____
(Name)	(Relationship)	(Phone)

Expiration date for this designation (unless/until you specify in writing the expiration, this form will remain in effect indefinitely or until patient expires).

_____ _____

Patient Signature Date

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During my care at Gallagher Podiatry,
_____ I am aware that all my outstanding balances need to be paid in monthly payments or in full. If this is not done, the balance plus fees and penalties will be added to my account before going to a Third Party Collection Agency.

Signature_____
Date_____

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