

COLORADO SPRINGS FOOT AND ANKLE CLINIC

F. James Gremillion, DPM, MS • Lee T. Fleming, DPM

3100 N. Academy Blvd., Suite 115
Colorado Springs, CO 80917**(719) 574-9800****www.csfoot-ankle.com****Podiatric Record**

This complete record is confidential

Today's Date _____

Medical Alerts	Patient's Name			Gender M F	Marital Status S M W D
	Residence Address			Age	Date of Birth
	City	State	Zip	Social Security No.	
	Home Phone	Cell	Driver's License No.		
Employed By & Address Of Employment			Occupation	Business Phone	
Spouse's Name		Employed By	Social Security No.	Phone #	
Parent or Guardian's Name if a Minor		Employed By	Social Security No.		
Name, address and phone of a contact in case of emergency (Relationship)					
If other than patient, name and address of person responsible for this account					
Do you have <input type="checkbox"/> Yes Medical Ins? <input type="checkbox"/> No	Carrier Name	Subscriber Name	Policy No.	Is it through <input type="checkbox"/> Yes your employer? <input type="checkbox"/> No	
Is there secondary ins? <input type="checkbox"/> Yes <input type="checkbox"/> No	Carrier Name	Subscriber Name	Policy No.		
First & Last Name of Family Physician		Are you currently under your physician's care? <input type="checkbox"/> Yes <input type="checkbox"/> No		Phone No.	
What medicines do you take regularly?				Date Last Seen: / /	
What medicines do you take regularly?				May we contact your physician <input type="checkbox"/> Yes for your health records? <input type="checkbox"/> No	
Name of former podiatrist	What treatment was received?		When was this treatment?		
Current foot complaint is:					
This condition(s) has existed for: _____ Days _____ Weeks _____ Months _____ Years			How did you hear about our office? DR Friend Other		
May we have your permission to send records and operative reports to your family physician? <input type="checkbox"/> Yes <input type="checkbox"/> No					

I authorize payment of medical benefits to the above physician and release of any information necessary to process or collect this claim. I am responsible for charges regardless of insurance coverage, and it is agreed that payment will not be delayed or withheld because of insurance coverage. If payment is not received within 30 days, after treatment, a 1 1/2% billing charge may be added on my account. I am responsible for any expenses incurred during collection of unpaid balance.

I hereby give Dr. F. James Gremillion or Dr. Lee T. Fleming permission to examine and treat my feet.

Patient's Signature _____

If a minor parent or guardian's signature _____

Relationship to minor _____

Note: By signing this agreement you are agreeing to have any issue of medical malpractice decided by neutral binding arbitration rather than by a jury or court trial.

You have the right to seek legal counsel and you have the right to rescind this agreement within 90 days from the date of signature by both parties unless the agreement was signed in contemplation of hospitalization in which case you have 90 days after discharge or release from the hospital to rescind the agreement.

No health care provider shall withhold the provision of emergency medical services to any person because of that person's failure or refusal to sign an agreement containing a provision for binding arbitration of any dispute arising as to professional negligence of the provider.

No health care provider shall refuse to provide medical care services to any patient solely because such patient refused to sign such an agreement or exercised the 90 day right of rescission.

Patient's Signature _____ Date: / /