Greenberg Foot & Ankle, LLC

1989 Miamisburg Centerville Rd Ste 200
Dayton OH 45459
P: 937-938-6444   F: 937-834-8636
www.GFAOhio.com

Welcome to Greenberg Foot & Ankle!

We are providers of medical and surgical management of foot and ankle disorders, providing comprehensive care for patients of all ages. Our offices are staffed and equipped to treat medical conditions with the most modern and appropriate techniques available. We strive to provide you with the best service possible with the caring you expect from the area's leading physicians in the treatment of the lower extremity.

Please familiarize yourself with our office policies on these registration forms. A copy of the Notice of Privacy Practices can be found as a downloadable form on our website in addition to the registration desk when you arrive for your appointment.

Please see our website for our current office COVID-19 policies.

Greenberg Foot & Ankle is committed to making our office a safe and healthy place for our patients and medical staff. Mask requirement in our office is determined on a day to day basis. Please understand that we are self-employed and not governed exclusively by any hospital network or medical group. Therefore, our policies may differ in some ways to medical groups and the hospital/medical center in close proximity to our offices.

You can find useful information and answers to your questions at the websites for the Ohio Department of Health (ODH) and the Center for Disease Control (CDC).

When you come to one of our offices for the first time, please arrive 15 minutes early and bring the following items with you:

1. Completed and signed registration forms
2. Current insurance card(s)
3. Method of payment for services (cash, check or charge), including copays and deductibles if they apply
4. Parent or guardian if the patient is a minor (under age 18)

Cancellations/Late Arrivals/Missed Appointments:

We understand that circumstances arise that can make you late or miss your appointment. Please have the courtesy to inform our staff as soon as possible if you are unable to keep your appointment. As a specialist our schedule fills up quickly, so giving us notification if you are unable to keep your appointment allows us to schedule other patients in that appointment time.

If you arrive late for your appointment, we reserve the right to reschedule you for another date.

Multiple cancellations and/or missed appointments may result in missed appointment fees or even the dismissal from the practice.

We thank you for choosing Greenberg Foot & Ankle. We hope your experience is a good one, we take great pride in the work and care we give to our patients. The greatest compliment is the trust you put in our physicians and staff and by referring family and friends to our office.

Greenberg Foot & Ankle

937-938-6444

Washington Township Medical Arts Center
formerly Southview Medical Arts Center
1989 Miamisburg Centerville Rd
Suite 200
Dayton, OH 45459

Your appointment:
Date ____________________
Time ____________________

NEW PATIENT

PATIENT INFORMATION

LEGAL NAME: ______________________________
FIRST MIDDLE LAST

ADDRESS: ______________________________

CITY, STATE, ZIP ______________________________

PRIMARY PHONE NUMBER ______________________________ ❑ HOME ❑ CELL

SECONDARY PHONE NUMBER ______________________________ ❑ HOME ❑ CELL

EMAIL ADDRESS ______________________________
FOR PATIENT PORTAL USE AND APPOINTMENT REMINDERS

SOCIAL SECURITY: ______________________________

DATE OF BIRTH ____________________ (MM/DD/YYYY)

MARITAL STATUS ☐ SINGLE ☐ MARRIED ☐ DIVORCE ☐ WIDOWED

SEX ☐ MALE ☐ FEMALE ☐ OTHER ____________________

EMERGENCY CONTACT

NAME: ______________________________

RELATIONSHIP TO PATIENT: ______________________________

CONTACT NUMBER: ______________________________

FAMILY DOCTOR/PRIMARY CARE PHYSICIAN

NAME ______________________________

CITY ______________________________

OFFICE PHONE NUMBER: ______________________________

PHARMACY

NAME: ______________________________

ADDRESS/CITY ______________________________

PHONE ______________________________

REFERRAL SOURCE

❑ FAMILY/FRIEND/CURRENT PATIENT ❑ FAMILY DOCTOR/PCP

❑ GFA WEBSITE ❑ OTHER DOCTOR/SPECIALIST

❑ INSURANCE COMPANY ❑ DR ____________________

❑ INTERNET SEARCH ❑ OTHER

____

FINANCIALLY RESPONSIBLE PARTY

❑ SELF (SKIP SECTION) ❑ OTHER (FILL IN BELOW)

RELATIONSHIP TO PATIENT ____________________

LEGAL NAME: ______________________________
FIRST MIDDLE LAST

ADDRESS: ______________________________

CITY, STATE, ZIP ______________________________

PRIMARY PHONE NUMBER ______________________________ ❑ HOME ❑ CELL

SOCIAL SECURITY: ______________________________

DATE OF BIRTH ____________________ (MM/DD/YYYY)

INSURANCE INFORMATION

PRIMARY INSURANCE: ☐ SELF PAY

POLICY HOLDER ❑ SELF ❑ RESPONSIBILE PARTY LISTED ABOVE ❑ OTHER (FILL IN BELOW)

COMPANY NAME: ______________________________

POLICY HOLDER'S NAME: ______________________________

POLICY HOLDER'S DATE OF BIRTH: ______________________________

RELATIONSHIP TO PATIENT: ______________________________

SECONDARY INSURANCE:

☐ NOT APPLICABLE (NO SECONDARY INSURANCE)

POLICY HOLDER ❑ SELF ❑ RESPONSIBILE PARTY ❑ OTHER (FILL IN BELOW)

COMPANY NAME: ______________________________

POLICY HOLDER'S NAME: ______________________________

POLICY HOLDER'S DATE OF BIRTH: ______________________________

RELATIONSHIP TO PATIENT: ______________________________

I certify that the information I have given is true and correct.

____

SIGNATURE **DATE**

MEDICAL HISTORY

Patient____Date of Birth _________________________

Circle the reason(s) for which you are seeing the doctor today:

Infection	Ingrown toenail	Nail fungus	Routine nail care	Diabetic foot check
Pain	Injury / Accident	Work Injury	Bunion	Hammertoes
Heel / Arch pain	Plantars wart	Corns / Call	Tailors bunion	Second opinion
Neuroma	Arthritis	Gout	Athlete's foot	Skin problem / Rash
Unknown mass	Foot ulcer	Joint pain		

Other:____

Have you seen a podiatrist before? Yes No Have you seen a doctor for the same reason you are here today? Yes No

Circle the medical conditions that you have now or have had in the past:

AIDS / HIV	Currently breast feeding	Heart attack	Peripheral Neuropathy
Anemia	Currently or possibly pregnant	Hepatitis A / B / C	Poor circulation
Angina	Depression / Anxiety	Hiatal hernia	Prostate - BPH
Anorexia / Bulimia	Diabetes type 1 / type 2	High blood pressure	Psychiatric disorder
Arthritis __________	Digestive disease	High cholesterol	Restless Leg Syndrome
Asthma	Drug or Alcohol dependency	Hyper- / Hypothyroidism	Sickle cell disease / trait
Bleeding disorder	Emphysema / COPD	Kidney disease	Skin disorder ____________
Blood clot / DVT / PE	Epilepsy / Seizure disorder	Liver disease	Sleep apnea
Cancer __________	Fibromyalgia	Mitral valve prolapse	Smoker
Cardiac Arrhythmia	Glaucoma / Cataracts	Multiple Sclerosis	Stomach ulcer / GERD
Congestive heart failure	Gout	Overweight / Obesity	Stroke / TIA
CRPS / RSD	Hearing loss	Parkinson's Disease	Tuberculosis

Others: ____

Current Medications: (Attach list if needed. Include both prescription and over-the-counter.)

________________________ ________________________ ________________________ ________________________

________________________ ________________________ ________________________ ________________________

________________________ ________________________ ________________________ ________________________

Allergies and Sensitivities:

____

____

____

Past Surgeries:

____

Complications with anesthesia? Yes No ____________________

Artificial joints or valves? Yes No ________________________

Are there any medical conditions that run in your family? (Blood relatives only)

Mother's side:	Don't know	No	Yes:________________________________
Father's side:	Don't know	No	Yes:________________________________
Children:	Don't have any	No	Yes:________________________________

Greenberg Foot & Ankle, LLC

ASSIGNMENT OF BENEFITS, FINANCIAL POLICY & PATIENT COMMUNICATIONS

ASSIGNMENT OF INSURANCE BENEFITS: I understand that providing accurate and active insurance information to Greenberg Foot & Ankle, LLC is my responsibility. I authorize any insurance payment on my behalf by my health insurance company, third party administrators, Medicaid or Medicare to be paid directly to Greenberg Foot & Ankle, LLC.

PRE-CERTIFICATION/PRIOR AUTHORIZATION: In some cases, a pre-certification is required, and we will do our best to obtain it for you, however it is your responsibility to know your contract. If it is required, please inform us so we may obtain prior approval for you.

In some cases a referral from your primary care physician is required and it is your responsibility to obtain this written authorization or referral before each visit or be sure that follow up visits are covered under your primary referral; failure to do so places the financial responsibility on you.

Some insurance plans require that you see your primary care physician within 6 months prior to seeing Dr. Greenberg. It is your responsibility to be in compliance with your insurances plan's requirements; failure to comply with your insurance requirements places financial responsibility on you.

FINANCIAL AGREEMENT: I agree to pay Greenberg Foot & Ankle, LLC for my deductible, coinsurance, co-payments and for services not covered by my insurance plan; this includes services that are out of my insurance company network. If I fail to provide accurate, active insurance information, I/my responsible party will be responsible for the balance on my account. If I do not have insurance, I agree to pay for services according to standard self-pay charge rates.

I understand that payments, which include copays, self-pay amounts and deductibles, are due in full at the time of service or at the time of first billing statement.

Our office has a returned check fee is $50.

MISSED APPOINTMENTS/CANCELLATIONS:

We understand emergencies and schedule conflicts arise, but we ask that you call our office to reschedule or cancel an appointment more than 24 hours prior to your appointment. If you arrive late for your scheduled appointment we reserve the right to reschedule you

> There is a **$50 fee** for no-show/missed or cancelled appointments less than 24 hours prior to scheduled appointment time for office visits.
>
> There is a **$100 fee** for missed or cancelled appointments less than 72 hours prior to scheduled appointment time for office surgeries and pre-op consultation appointments.

COMMUNICATION: I authorize Greenberg Foot & Ankle and it's partners to contact me using the email address or any phone number provided in the past, present, or future. This includes authorization to contact me on my mobile phone, even if this may result in charges from my wireless provider I agree that I may be contacted by a pre-recorded or artificial voice message and or automatic telephone dialing system, or by text message as applicable.

HIPAA Privacy Practices have been made available to me.

I have read the above items, or it was read to me and was explained to my satisfaction.

____ ________________________

Signature of Patient, Parent or Legal Guardian   Date