HARRY G.
BALDINGER, D.P.M.
MEDICINE & SURGERY OF THE FOOT

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Welcome to our office

TODAY'S DATE: _____/_____/_____

LAST NAME: _____ FIRST NAME: _____ CHART # 17_____

SOCIAL SECURITY #: _____–_____–_____ DATE OF BIRTH:_____ CURRENT AGE: _____

HOME ADDRESS: _____ UNIT/APT: _____ HOME PHONE: _____

CITY: _____ STATE: _____ ZIP: _____ EMAIL:_____

WORK PLACE: _____ WORK PHONE: (____) ____- _____

WORK ADDRESS: _____ CITY: _____ STATE: _____ WORK ZIP: _____ EMAIL:_____

WHO MAY I THANK FOR TELLING US ABOUT OUR OFFICE?_____ CELL PHONE: _____

REASON FOR TODAY'S VISIT:_____

_____

YOUR HEIGHT: _____' _____" USUAL WEIGHT: _____ LBS USUAL SHOE SIZE: _____

PRIMARY PHYSICIAN: DR. _____ PHYSICIAN PHONE #: _____

PRIMARY DENTIST: DR. _____ DENTIST PHONE #: _____

PHARMACY: _____ PHONE #: _____ ZIP: _____MOTHER'S MAIDEN NAME:_____

MEDICATION LIST PAST AND CURRENT: _____

ALLOW TO RETRIEVE ☐**Y** ☐**N** PROTECT FROM OTHER DOCTORS ☐**Y** ☐**N**

Office Policy: PLEASE READ, AND BY SIGNING BELOW YOU AGREE:

- ☐ I AM AWARE THAT DR. BALDINGER DOES NOT PARTICIPATE WITH ANY INSURANCE COMPANY OR PLAN.
- ☐ I AM ULTIMATELY RESPONSIBLE FOR MY BILL AND MEDICAL SERVICE FEES ARE NON-NEGOTIABLE.
- ☐ I WILL BE PAYING FOR MEDICAL SERVICES TODAY BY ☐ CHECK ☐ CASH ☐ CREDIT CARD
- ☐ HARD COPIES OF X-RAYS WILL BE CHARGED $50.00. EMAIL COPIES ARE FREE.
- ☐ PREAUTHORIZATION (OF MEDICAL SERVICES OR MEDICATIONS) REQUESTED BY YOUR INSURANCE COMPANY WILL BE CHARGED $50.00 PER HALF HOUR OF DOCTOR'S TIME.
- ☐ LETTERS OR UNUSUALLY LENGTHY/FREQUENT PHONE CALLS WILL BE CHARGED AT $50.00 PER ITEM.
- ☐ THERE ARE NO RETURNS ON ITEMS DISPENSED WITH YOUR VISIT.
- ☐ I WILL NOTIFY DR. BALDINGER OF ANY CHANGE IN MY HEALTH STATUS, MEDICATIONS OR ANY OF THE ABOVE PERSONAL INFORMATION PROMPTLY.
- ☐ I AUTHORIZE RELEASE OF MEDICAL INFORMATION NEEDED TO PROCESS ANY INSURANCE CLAIMS
- ☐ PLEASE SEND THE CLAIM TO MY INSURANCE CARRIER:_____

POLICY #:_____ GROUP #:_____

SIGNATURE OF PATIENT/PARENT: _____ DATE: _____/_____/_____