GREGORY N. BENTZEL, DPM
DIPLOMATE AMERICAN BOARD OF PODIATRIC SURGERY
CERTIFIED IN FOOT AND ANKLE SURGERY

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GREER, SC 29650

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WELCOME TO OUR OFFICE

MR, MRS, MS, DR:_____ Date of Birth:_____

What Name Do You Like To Be Called: _____

Address:_____City:_____State: _____ Zip:_____

E-mail:_____ ❑ Home or ❑ Work email

Telephone: _____ Social Security #: _____

Age: _____ Sex: ___M ___F Weight: _____ Height: _____ Shoe Size: _____

Single: _____ Married: _____ Widowed: _____ Separated: _____ Divorced: _____

Employed By: _____ Occupation: _____ Bus. Phone: _____

Employer Address: _____

Medical Insurance Co.: _____ Policy No. _____

Name of Subscriber: _____ Date of Birth:_____

Do You Have Other Health Insurance Coverage? Yes ___ No ___ Insured SS # _____ DOB _____

Medical Insurance Company: _____ Policy No. _____

OFFICE POLICY REGARDING INSURANCE

To preserve the best possible relationship with you, our patient, and to prevent any misunderstanding, we hope the following explanation of our office policy regarding insurance and payment for services is helpful.

1) Professional services are rendered and billed directly to your insurance carrier; however you, the patient/guardian, are directly responsible for services rendered by the doctor. A health insurance policy is a contract between you (the patient or subscriber) and your insurance carrier. If for any reason the insurance carrier denies charges, payment for any services rendered will become the responsibility of the patient/guardian.

2) We expect and appreciate payment for office visits at the time of service. We will accept cash, check, MasterCard, Visa or debit card.

3) For any insurance plan that requires authorization from a primary care physician (e.g. HMO, PPO, etc.) it is your responsibility (as patient or guardian) to be sure that this office receives all necessary referrals or authorizations PRIOR to treatment. If the insurance carrier denies any charges due to lack of referral authorization, you (the patient or guardian) are responsible for all charges incurred.

4) If any type of supplies are dispensed during the course of treatment, (e.g. arch supports, accommodative pads, creams, surgical shoes, etc) payment is due at the time of service. We cannot bill you or the insurance company for these supplies.

5) I have read, understand and agree to the above office policies and understand that I am financially responsible for any balance due on my account.

6) I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read if I so chose) and understood the Notice.

✘_____ _____

Signature (Parent, if patient is a minor) *Date*

PERMISSION TO DISCLOSE PROTECTED HEALTH INFORMATION
CONSENT AND ACKNOWLEDGEMENT

(PLEASE PRINT)

Patient Name _____ Date of Birth: _____

Patient Address _____ SSN: _____

_____

I give] Dr. Gregory N Bentzel, DPM, LLC permission to release medical information to the follow persons:

None

Parents _____ Spouse _____

Father (only) _____ Mother (only) _____

Other _____ Guardian _____

I wish to be contacted in the following manner by Dr. Gregory N Bentzel, DPM, LLC (check all that apply):

Home Telephone _____
O.K. to leave message with detailed information
Leave message with call back number only

Work Telephone _____
O.K. to leave with detailed information
Leave message with call back number only

Written Communication
O.K. to mail or Email to my home address
O.K. to mail or Email to my work/office
O.K. to fax to this number _____
Other (Email address)

The Privacy Act generally requires healthcare providers to take responsible steps to limit the use of disclosure of and requests for protected health information to the minimum necessary to accomplish the intended purpose. These provisions do not apply to uses or disclosures made pursuant to an authorization requested by the individual.

Healthcare entities must keep records of protected health information disclosures. Information provided below, if completed properly, will constitute an adequate record.

CONSENT:
I consent to the use and disclosure of protected health information about me by my physician and my physician's practice for purposes of treatment, payment, health care operations, protection of others and disclosures required by law, including information about notifiable diseases, sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), and human immunodeficiency virus (HIV).

NOTE: Uses and disclosures for protected health information may be permitted without consent in an emergency.

ACKNOWLEDGEMENTS:

I acknowledge that I have received Dr. Gregory N. Bentzel, DPM, LLC Notice of Privacy Practices.

_____ _____
Signature of Patient or Personal Representative Date

_____ _____
Relationship of Personal Representative to the Patient Signature of Witness

_____
Print personal Representative's Name

Welcome to Our Office

My goal is to provide you the highest quality foot to ensure that you continue to perform your daily activities without pain. Whether it is standing at work, exercising, or just performing your daily routine, our medical care is directed toward a rapid recovery.

I always try to provide pain relief with conservative methods such as shoe recommendations, custom made orthotics, medications or protective devices. The majority of time these are the most effective treatments and one is able to avoid surgery.

When conservative methods are ineffective, sometimes surgical intervention is necessary. If you require surgical treatment I will provide you with complete explanations regarding your procedure with realistic expectations and outcomes.

Our office has the latest technology, including diagnostic ultrasound and laser treatment for fungal nail disease and spider veins of the foot and ankle. Give our office a call today and let myself and staff begin to help you with your foot problems

Medical Information

Have you ever had, or been treated for, any of the following?

MAJOR DISEASE
- ❑ Diabetes
- ❑ High Blood Pressure
- ❑ Angina
- ❑ Heart Disease
- ❑ Heart Attack
- ❑ Arrhythmia
- ❑ Heart Murmur
- ❑ Mitral Valve Prolapse
- ❑ Stroke
- ❑ High Cholesterol

HEENT
- ❑ Headaches
- ❑ Glaucoma
- ❑ Hearing Problems

RESPIRATORY
- ❑ Asthma
- ❑ Tuberculosis
- ❑ Emphysema

ARTHRITIS
- ❑ Osteoarthritis
- ❑ Rheumatoid
- ❑ Gout

VASCULAR
- ❑ Anemia
- ❑ Prolonged Bleeding
- ❑ Pacemaker
- ❑ Poor Circulation
- ❑ Leg Pain When Walking
- ❑ Varicose Veins
- ❑ Blood Clots

GASTROINTESTINAL
- ❑ Ulcers
- ❑ Acid Reflux (GERD)
- ❑ Stomach Problems
- ❑ Hiatal Hernia
- ❑ GI or Rectal Bleeding
- ❑ Bowel Disorders

MISCELLANEOUS
- ❑ Epilepsy/Seizures
- ❑ Thyroid Disease
- ❑ Muscle Disease/Polio
- ❑ Kidney Problems
- ❑ Bladder Problems
- ❑ Prostate Problems
- ❑ HIV
- ❑ Hepatitis/Liver Disease
- ❑ Cancer (type:_____)

PSYCHOLOGICAL
- ❑ Anxiety
- ❑ Depression
- ❑ Psychiatric Care
- ❑ Drug Dependence
- ❑ Alcohol Dependence

OTHER MEDICAL PROBLEMS:

_____

_____

_____

_____

_____

Primary Doctor: _____ Last visit: _____

Address: _____

Previous Podiatrist: _____ Last visit: _____

What is your foot/ankle problem? _____

How long has it been present? _____ weeks _____ months _____ years

What surgeries or operations have you had? _____

_____

What prescription medications are you now taking? _____

_____

Are you allergic to any of the following?

❑ Latex ❑ Novocaine ❑ Iodine ❑ Penicillin ❑ Codeine ❑ Aspirin ❑ Adhesive Tape ❑ Tetanus

Do you have any other allergies/ sensitivities? ❑ Yes ❑ No If yes, what? _____

Do you smoke? ❑ Yes ❑ No If yes, how many packs per day?_____

Do you drink alcohol? ❑ Yes ❑ No If yes..... ❑ Socially ❑ Daily

(WOMEN) Are you pregnant? ❑ Yes ❑ No

I hereby give my permission to **Dr. Gregory N. Bentzel, DPM, LLC** to administer treatment and to perform such procedures as may be deemed necessary in the diagnosis and/or treatment of my foot condition, and authorize, to the extent necessary, disclosure of medical information to assist in processing my insurance claim and to communicate with the treating physicians. Furthermore, I assign all payment of medical benefits provided by my insurance company policy for medical/surgical care to Dr. Gregory N. Bentzel, DPM, LLC

Signature:_____ Date:_____

(Patient or the person authorized to consent for the patient)

Relationship to patient _____