Family Foot and Ankle Clinic Paul Sommer, DPM, FACLES
(219) 477 – Foot (3668)
www.familyfoot.com
Facebook: Paul Sommer Podiatry
Twitter: @FootCare

Valparaiso ~ Chandana Pointe ~ 1610 Pointe Drive.
DeMotte ~ DeMotte Clinic ~ 520 Eighth Avenue NE

Dear Patient:

Welcome to Family Foot & Ankle Clinic.

Excellent patient care is our goal. We want you to be well informed and satisfied with your medical care at Family Foot & Ankle Clinic.

Please take a few moments to fill out the enclosed papers. All pages and lines should be completed. Filling them out in their entirety will help us with your registration information and medical information. You will need to bring them both with you for your first appointment on: _____ at _____ in our Valparaiso / DeMotte office.

Please bring a photo I.D. as well as your current health insurance card(s). All co-pays and deductibles are due at time of service.

It is also important to bring any recent x-rays, MRI, CT, Ultrasounds, and reports which are related to the problem for which you are coming to our clinic. You may need to call the facility where the testing was done to obtain copies needed to bring to your appointment with Dr. Sommer. It is always a good idea to give the facility 24-48 hours notice prior to picking up your records.

Please feel free to call our office if you have any other concerns or questions at 219-477-Foot (3668).

We look forward to serving your foot care needs.

Sincerely,

Dr. Paul Sommer and Staff

Paul Sommer DPM

PATIENT INFORMATION

Name: _____ Age: _____Birthdate: _____

Address: _____City:_____St:_____Zip Code: _____

Social Security Number: _____Sex:_____ Marital Status: S / M / D / W

Shoe Size and Width: _____ Approximate Weight_____

Home Phone: _____Cell Phone: _____

Pharmacy: _____Location:_____ Phone: _____

E-Mail Address: _____ (this info is never shared)

Have You Visited Our Website? Yes / No

May we send you periodic email newsletters? Yes / No

Occupation: _____Employer:_____

Employer's Address: _____ Phone: _____

City: _____ State: _____ Zip: _____

Nearest Relative Not At Your Address: _____Phone:_____

Spouse Or Parent's Name: _____Phone:_____

Insurance Information (We will need a copy of your insurance card)

Insurance Co: _____

Guarantor: _____Birth date: _____

Guarantor Social Security Number: _____

Family Doctor: _____Phone:_____

Former Podiatrist: _____

What did that Podiatrist treat you for? _____

_____

What condition brings you to the office today? _____

_____

How were you referred to this office? (Circle All That Apply)

1. Doctor 2. Family Member 3. Friend 4. Yellow Pages 5. Sign

6. Web site 7. Health Fair 8. Facebook 9. Insurance network 10. Hospital

Whom may we thank for referring you? _____

Paul Sommer DPM

Please Circle "Yes" or "No"

Are You In Good Health? Yes No

Have you been Under a Doctor's Care in the Past Year? Yes No

Have You Ever Had Any Broken Bones Of The Foot/Leg/Hip Yes No

Which Bones And When? _____

Have You Ever Had Any Foot Surgery Yes No

What Surgery and When? _____

List All Other Surgeries You Have Had: _____

_____

Have You Ever Had Any Of The Following? (please circle)

Diabetes, High Blood Pressure, Bleeding Problems, Healing Problems, Foot Ulcers,

Foot Infections, Circulation Problems, Arthritis, Liver Disease, Lung Disease,

Heart Disease, Kidney Disease, Tuberculosis, Epilepsy, AIDS, Cancer, Asthma,

Chemical Dependency, Psoriasis, Stroke, Athlete's Foot, Back Pain, Neuropathy.

Do you smoke? Yes No How much and how long? _____

List All Allergies To Medications: _____

List All Medications You Are Currently Taking: _____

_____

List Vitamins and Supplements: _____

"I hereby give permission to Dr. Paul Sommer and staff to administer treatment and to perform such procedures as may be necessary in the diagnosis and treatment of my condition. I authorize release of information necessary to process my insurance claims. I authorize the photography and/or x-ray of my feet for medical records. I authorize payment of medical benefits to Dr. Paul Sommer for services rendered. We will file all insurance plans, but it is the responsibility of the patient/guardian to contact their insurance company for in or out of network benefits.

I further understand that I am responsible for payment of any and all charges incurred. If it becomes necessary to turn my account over to collections, I will be fully responsible for any and all fees, including reasonable attorney fees incurred therein."

"I fully understand that payment for all services is due on the day that services are rendered including insurance co-pay and deductible."

"I understand that failure to meet appointments without 24 hour notice will result in a $35 surcharge."

Signature of Patient: _____

or Legal Guardian: _____

Date: _____

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www.familyfoot.com 477- Foot (3668) Paul Sommer, DPM, FACLES

Please fill this out completely and accurately on this form, and bring it with you to your appointment.

Date: _____

PATIENT: _____

Allergies to medications: _____

MEDICATIONS	**VITAMINS AND/OR SUPPLEMENTS**	DOSAGE	WHEN WAS MEDICATION STARTED?	PRESCRIBING DOCTOR	**DATE CK'D**	**EMPLOYEE INITIALS**

By the signature below, I acknowledge that I have received, read and understand the:

"NOTICE OF PRIVACY PRACTICE: OUR COMMITMENT TO YOUR PRIVACY" policy form of **Family Foot and Ankle Clinic**, and that this signature will be kept in patient's file.

Patient Name
(Print):_____

List individual names with whom we may discuss your medical information (other than Healthcare providers.)

1. _____
2. _____
3. _____
4. _____

Signature of legally responsible party: _____

Date: _____

OR: I **refuse** to accept/sign the above notice of privacy

Signature: _____ Date: _____

FAMILY FOOT AND ANKLE CLINIC
PAUL SOMMER DPM

CANCELLATION POLICY

Thank you for choosing Family Foot and Ankle Clinic for your healthcare needs. When you schedule an appointment with Dr. Sommer, we reserve this time slot for you to be seen. Should you need to cancel or reschedule this appointment, please call the Valparaiso office at (219) 477-3668 or DeMotte office at (219) 987-2700, as soon as possible to do so. We will accommodate your needs to the best of our ability.

Due to the large number of patients and our high standard of care, please notify us if you will be more than 15 minutes late, as we may have to reschedule your appointment. Please notify us of cancellations or reschedules at least 24 hours in advance. Failure to do so can result in a $35.00 charge.

Please review the above information and sign below. Your signature indicates that you understand this policy and agree to abide by it.

Print name: _____ Date: _____

Signature: _____

PAUL SOMMER DPM
1610 POINTE DR. SUITE C
VALPARAISO, IN 46383

E-Statement Authorization

Our practice now has the ability to send your account statement to you via email each month. This email will include a link to a secure webpage where you can view your statement and also make a payment online using a debit/credit card. We would like to offer you the opportunity to receive your account statement by email. By agreeing to receive your monthly account statement via email, you are not only helping the environment, but also gaining the convenience of making payments online at any time of the day or night.

Please indicate your choice by checking the appropriate box and sign below. Please provide your current email address if you authorize the use of eStatements for your account:

☐ **YES, PLEASE SEND MY ACCOUNT STATEMENT TO MY EMAIL ADDRESS.**

(PLEASE PRINT CLEARLY)

My email address is _____

☐ **NO, PLEASE CONTINUE TO SEND MY ACCOUNT STATEMENT THROUGH THE POSTAL SERVICE.**

_____ _____

Patient name (print) Date of Birth

_____ _____

Signature Today's Date