

PATIENT INFORMATION

Date _____

Patient _____
(Last) (First) (Initial)

Address _____
City State Zip

Sex: M F Age _____ Birthdate _____

Marital Status: Single Married Widowed
 Separated Divorced

Patient SS# _____

Occupation _____

Employer _____

Employer Address _____

Employer Phone _____

Spouse's Name _____

Birthdate _____ SS# _____

Occupation _____

Spouse's Employer _____

Whom may we thank for referring you? _____

PHONE NUMBERS

Home _____ Work _____ Ext _____

Best time and place to reach you _____

IN CASE OF EMERGENCY, CONTACT:

Name _____ Relationship _____

Home Phone _____

Work Phone _____ Ext _____

INSURANCE

Insurance Co. _____

Name of insured _____

Group # _____ ID # _____

Relationship to Patient _____

Is patient covered by additional insurance? Yes No

Subscriber Name _____

Birthdate _____ SS# _____

Relationship to Patient _____

Secondary Ins. Co. _____

Group # _____ ID # _____

Name of insured _____

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage with _____

and assign directly to Advanced Podiatry Associates, L.L.C. all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party Signature _____

Relationship _____ Date _____

MEDICARE AUTHORIZATION

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Advanced Podiatry Associates, L.L.C. for any services furnished me by that physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

Beneficiary Signature _____ Date _____

PODIATRIC HISTORY

What is the chief complaint for which you came to be treated? (Include foot, ankle, knee, thigh, and hip complaints.)

Onset: _____
Duration: _____

Have you ever been to a Podiatrist before? Yes No
If yes, please list.

Name _____
Last visit _____

Is there any personal or family history of diabetes? Yes No

Your occupation _____

Cigarette/Tobacco use _____

Years smoked _____

Alcohol _____ Coffee (cups/day) _____

Athletic activities in which you participate (please list and indicate frequency)

Please indicate which foot problems you now have or have had in the past.

- Ankle Pain Yes No
- Athlete's Foot Yes No
- Bunions Yes No
- Corns and Callouses Yes No
- Cramps or Numbness in Feet or Legs Yes No
- Flat Feet Yes No
- Foot or Leg Cramps Yes No
- Heel Pain Yes No
- Ingrown Toenails Yes No
- Plantar's Warts Yes No
- Swelling in Ankles or Feet Yes No
- Tired Feet Yes No