PATIENT REGISTRATION & HISTORY

PENNSYLVANIA Foot & Ankle ASSOCIATES

- ☐ 1304 Rhawn Street, Philadelphia, PA 19111 • 215.742.1225
- ☐ 301 Oxford Valley Rd., Suite 204, Yardley, PA 19067 • 215.493.8300
- ☐ 2808 N. 5th Street Hwy, Reading, PA 19605 • 610.921.8800
- ☐ 13 Market Place, Suite 60, New Hope, PA 18938 • 215.862.2084
- ☐ 2285 Cross Rd, Glenside, PA 19038 • 215.887.1784

Bruce L. Bruskoff, DPM, FACFAS
David S. Wander, DPM, FACFAS
Robert Rajczy, DPM, AACFAS
Jack Rubinlicht, DPM, FACFAS
Andrew J. Sohl, DPM, AACFAS
Nafisa Hasan, DPM
Howard D. Goldhammer, DPM, FACFAS
Jay Schnitzer, DPM, FACFAS
Leona Velicov, DPM

PATIENT INFORMATION

Name _____ Date _____

Address _____

_____

City _____ State _____ Zip _____

Sex M F Single Married Separated Divorced

Age _____ Birthdate _____

Occupation _____ Patients SS# _____

Employer _____

Employer's Address _____ Employer's Phone _____

Spouse's Name _____ Birthdate _____ SS# _____

Occupation _____ Spouse's Employer _____

Whom may we thank for referring you? _____

CONTACT INFORMATION

Email _____

Phone Home _____ Work _____ ext. _____

Mobile _____

IN CASE OF EMERGENCY

Name _____ Relationship _____ Phone _____

INSURANCE

Who is responsible for this account? _____ Relationship to Patient _____

Insurance Company _____

ID# _____ Group# _____

Is Patient covered by additional insurance YES NO

Subscriber Name _____ Birthdate _____ SS# _____

Relationship to Patient _____

Insurance Co. _____

ID# _____ Group# _____

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MEDICAL HISTORY 1

What is the chief complaint today.

_____

_____

Have you ever been to a Foot Doctor before YES NO if YES - Name _____ Last visit _____

Do you presently smoke? YES NO if YES - Years smoked _____

Have you previously smoked? YES NO I stopped _____

Is there a family history of Diabetes YES NO

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage with _____ and assigned directly to Dr. _____ 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 Dr. _____ 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, mt signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charges determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductibles, coinsurance, and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

Beneficiary Signature _____

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MEDICAL HISTORY 2 (check all that currently or previously apply to you):

- ☐ AIDS/HIV
- ☐ Allergies (specify)
- ☐ Allergies to Medicine or drugs
- ☐ Anemia
- ☐ Angina
- ☐ Arthritis
- ☐ Artificial Heart Valves or Joints
- ☐ Asthma
- ☐ Back Problems
- ☐ Bleeding Disorders
- ☐ Cancer (specify)
- ☐ Chemical Dependency
- ☐ Chest Pain
- ☐ Chronic Diarrhea
- ☐ Circulatory Problems
- ☐ Diabetes - Type I or Type II (Circle)
- ☐ Ear Problems
- ☐ Epilepsy
- ☐ Eye Problems
- ☐ Fainting/Dizziness
- ☐ Foot or Leg Cramps
- ☐ Gout
- ☐ Headaches
- ☐ Heart Disease
- ☐ Hemophilia
- ☐ Hepatitis or Jaundice
- ☐ High blood pressure
- ☐ High Cholesterol
- ☐ Kidney Problems
- ☐ Liver Disease
- ☐ Low Blood Pressure
- ☐ Nervous Problems
- ☐ Phlebitis
- ☐ Psychiatric Care
- ☐ Radiation Treatment
- ☐ Respiratory Disease
- ☐ Rheumatic Fever
- ☐ Shortness of Breath
- ☐ Sinus Problems
- ☐ Stroke / TIA
- ☐ Swelling in Ankles, Feet
- ☐ Swollen Neck Glands
- ☐ Thyroid Disease
- ☐ Tired Feet
- ☐ Tuberculous
- ☐ Ulcers
- ☐ Varicose Veins Venereal Disease
- ☐ Weight Loss, unexplained

Please list any other medical conditions not list above _____

Family Physician _____ Last Visit Date _____

Are you now, or have you been, under any other doctor's care for any reason over the past two years YES NO

If YES, please explain _____

Past Surgeries _____

_____

Hospitalization (other than for surgeries listed) _____

MEDICATIONS (include prescriptions, over-the-counter and vitamins)

_____

_____

Pharmacy Name(s) _____ Phone# _____

_____

Do you take oral contraceptives? YES NO

ALLERGIES

- ☐ Adhesive/Tape
- ☐ Anticoagulant Therapy
- ☐ Aspirin
- ☐ Codeine
- ☐ Demerol
- ☐ Iodine
- ☐ Local
- ☐ Novocaine
- ☐ Penicillin
- ☐ Seafoods
- ☐ Sulfa

Other _____

CONSENT

I certify that the above information is true and correct to the best of my knowledge. I give my permission to the doctor to administer and perform such procedures as may be deemed necessary in the diagnosis and/or treatment of my feet.

_____ _____

Patient's Signature Date