WELCOME

Date _____

Patient _____

Address _____

City_____ State ___ Zip _____

Sex _M _F Age ___Birth Date _____

Home Phone _____

Work or Cell Phone

_____

E-mail address

_____

Occupation

_____

Account holder information **if not you**:

Name:_____

Birth Date: _____

Relationship: _spouse _parent

Whom may we thank for referring you?

_____

In Case of Emergency, Contact:

_____

PLEASE NOTE: The patient or account holder is responsible for all copayments and deductibles. Co-pays are due at the time of the visit.

Insurance company:

_____

Insurance ID number

_____

Assignment and Release

I, the undersigned, certify that I, or my dependents assign insurance coverage directly to Dr. Howard E. Friedman DPM. I understand I am financially responsible for all charges. I authorize the office 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 Date

Medicare Authorization

I request the payment of authorized Medicare benefits be made on my behalf directly to Dr. Howard E. Friedman, DPM. The physician agrees to accept the charge determination of Medicare as the full charge and the patient is responsible for the deductible, coinsurance, and non-covered services. I have been given the opportunity to review patient privacy laws.

_____

Beneficiary Signature Date

Dr. Howard E. Friedman DPM
29 N. Airmont Road Suffern, NY 10901 845-357-2806
www.suffernpodiatry.com

WELCOME

What is the main concern with your feet? _____
_____
_____

Have you been to a podiatrist before?
____ yes ___no

Cigarette/Tobacco Use _____

List sports activities in which you participate. Indicate frequency.
_____
_____
_____

Indicate any other foot problems you have had in the past. _____
_____

Please list your physicians:
_____
_____

Medical problems you are being treated for: _____
_____
_____

Surgeries you have had:
_____
_____
_____

Family Medical History
_____
_____
_____

List the medications, prescription and non-prescription, you are taking:
_____
_____
_____
_____

List your drug allergies:
_____
_____

Your pharmacy name and location:
_____
_____

Do you have any of the following conditions?

Diabetes	**__ yes**	**__ no**
Heart	__yes	__no
Heart valve	__yes	__no
Pulmonary	__yes	__no
Arthritis	__yes	__no
Poor circulation	__yes	__no
Kidney problems	__yes	__no
High blood pressure	__yes	__no
Gout	__yes	__no
Blood clots	__yes	__no

Do you require antibiotics prior to a minor procedure? __yes __no

Any additional information: _____
_____
_____

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www.suffernpodiatry.com

WELCOME

I give my permission to Dr. Friedman for evaluation and treatment.

_____

Patient Signature Date

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