

# WELCOME

Date \_\_\_\_\_

Patient \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_ Zip \_\_\_\_\_

Sex \_M\_ \_F\_ Age \_\_\_\_ Birth Date \_\_\_\_\_

Home Phone \_\_\_\_\_

Work or Cell Phone \_\_\_\_\_

Patient SSN \_\_\_\_\_

Occupation \_\_\_\_\_

Employer \_\_\_\_\_

Employer Address \_\_\_\_\_

Employer Phone \_\_\_\_\_

Spouse's Name \_\_\_\_\_

Birth Date \_\_\_\_\_

SSN \_\_\_\_\_

Occupation \_\_\_\_\_

Spouse's

Employer \_\_\_\_\_

Whom may we thank for referring you? \_\_\_\_\_

In Case of Emergency, Contact: \_\_\_\_\_

Home \_\_\_\_\_ Work \_\_\_\_\_

## Insurance Information

Who is responsible for this account:

Relationship to patient \_\_\_\_\_

Insurance Co. \_\_\_\_\_

Group # \_\_\_\_\_

## Assignment and Release

I, the undersigned, certify that I, or my dependent 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 either to me or on my behalf directly to Dr. Howard E. Friedman, DPM. In Medicare assigned cases, the physician agrees to accept the charge determination of Medicare as the full charge and the patient is responsible only for the deductible, coinsurance, and non-covered services. Coinsurance and the deductible are based upon the charge determination of Medicare.

Beneficiary Signature \_\_\_\_\_ Date \_\_\_\_\_

I have received the notice of patient privacy and have been given the opportunity to review it.

Signature \_\_\_\_\_ Date \_\_\_\_\_

**Dr. Howard E. Friedman DPM**  
**29 N. Airmont Road Suffern, NY 10901 845-357-2806**  
**www.Yourfootdoc.net**

# WELCOME

What is the main concern with your feet? \_\_\_\_\_

\_\_\_\_\_

Have you been to a podiatrist before?

\_\_\_ yes \_\_\_ no

Name: \_\_\_\_\_

Last visit? \_\_\_\_\_

Your Occupation \_\_\_\_\_

Cigarette/Tobacco Use \_\_\_\_\_

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:

\_\_\_\_\_

\_\_\_\_\_

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?

Heart  yes  no

Heart valve  yes  no

Pulmonary  yes  no

Arthritis  yes  no

Poor circulation  yes  no

**Diabetes**  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: \_\_\_\_\_

\_\_\_\_\_

I give my permission to the doctor to perform such procedures as necessary for my feet.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date