

WELCOME

Date _____

Patient _____

Address _____

City _____ State ____ Zip _____

Sex _M_ _F_ Age ____ Birth Date _____

Home Phone _____

Work or Cell Phone

Email address

Patient SSN

Occupation

Employer

Employer Address

Guarantor's Name

Guarantor's Birth Date _____

Guarantor's Employer

Whom may we thank for referring you?

Emergency Contact Name and Phone:

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 dependant 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

Last visit? _____

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:

Family medical history (parents and siblings):

Your pharmacy name and location:

Do you have any of the following conditions?

Diabetes	___yes	___no
Heart valve	___yes	___no
Pulmonary	___yes	___no
Arthritis	___yes	___no
Poor circulation	___yes	___no
Heart	___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