

Primary Physician: _____

Date: _____

Physician Address: _____

Physician Phone: _____

Pharmacy Name/Number: _____

Patient Information

Name: _____
(First) (Middle) (Last)

Address: _____

City: _____ State: _____ Zip: _____ Home Phone () _____

Email Address: _____ Cell Phone () _____

Sex: _____ Date of Birth: _____ Age: _____ Height: _____ Weight: _____ Shoe Size _____ Shoe Width _____

Marital Status: (circle one) Single Married Divorced Widowed Social Security # _____

PRIMARY INSURANCE-SUBSCRIBER'S SOCIAL SECURITY NUMBER AND DATE OF BIRTH REQUIRED-

Subscriber Name: _____ Relation: _____ Date of Birth: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone #: () _____ Social Security #: _____

Employer: _____ Work Phone: () _____

Type of Insurance: _____ Policy # _____ Group # _____

SECONDARY INSURANCE- SUBSCRIBER'S SOCIAL SECURITY NUMBER AND DATE OF BIRTH REQUIRED-

Subscriber Name: _____ Relation: _____ Date of Birth: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone #: () _____ Social Security #: _____

Employer: _____ Work Phone: () _____

Type of Insurance: _____ Policy # _____ Group # _____

**COMMERCIAL - MEDICARE - SELF PAY - MVA
PERSONAL INJURY - WORKMAN'S COMPENSATION**

I request that payment of authorized benefits be made either to me or on my behalf to Foot & Ankle Specialists of Bucks County for any services furnished me by this office. I authorize any holder of medical information about me to the Health Care Financing Administration and its agents any information to determine these benefits or the benefits payable for related services. I hereby authorize my insurances to furnish to the above named office any information regarding my insurance claims under Title XVIII of the Social Security Act. I request that payment of Authorized Medigap benefits be made wither to me or on my behalf to the Foot & Ankle Specialists of Bucks County for any services furnished me by that physician/supplier. I authorized any holder of medical information about me to my Medigap Carrier any information needed to determine these benefits payable for related services.

I hereby authorize release of information necessary to file a claim with my insurance company and assign benefits otherwise payable to me, to the office indicated on the claim. I understand I am financially responsible for any services rendered by The Foot & Ankle Specialists of Bucks County. I authorize release of my medical information from this office to other health care providers. A copy of this signature is as valid as the original. I understand that I am financially responsible for all charges and balances for services rendered as well as 1.5% interest charge on any unpaid patient responsibility balance over 120 days past due.

X _____ NAME OF INSURED: _____
(signature) (please print name of insured)

Today's Date: _____

Family Physician: _____

Patient Name: _____ Date of Birth: _____

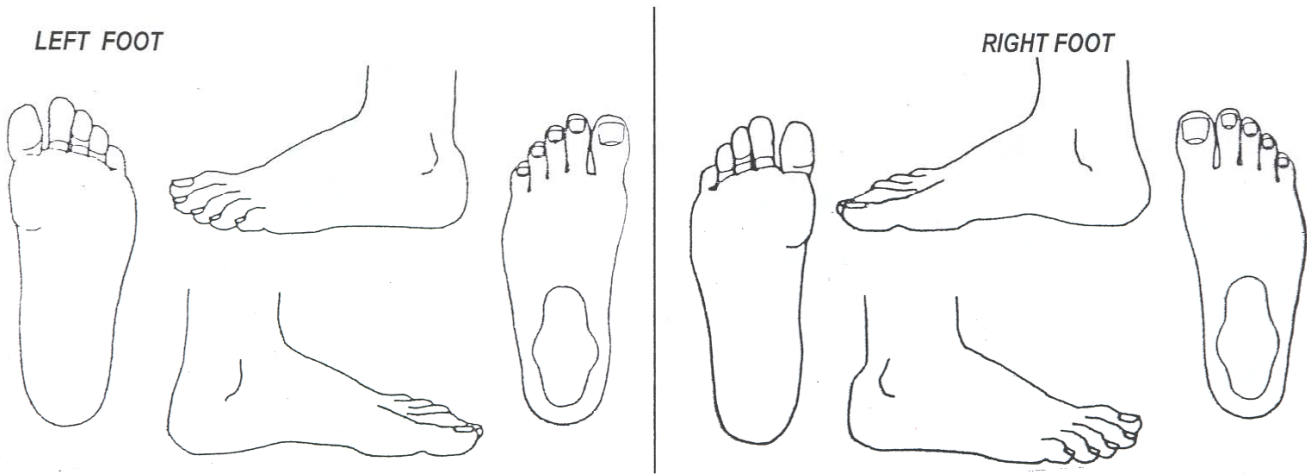
Please answer the following questions completely:

1. Describe your foot or ankle problem (detailed): _____

2. How many days, weeks, months, or years have you had this problem (specific) _____
3. Have you been treated prior for this problem? If so, by whom and when? _____

4. Is this a Workman's Compensation Claim/Personal Injury or Motor Vehicle related injury? Yes or No (Circle one)

Please Mark The Area Of Concern Below:



5. How were you referred to our practice? Yellow Pages Insurance Directory Sign
Patient / Friend Employee Doctor I was a previous patient
Whom may we thank? _____
6. Have you had previous treatment by another Podiatrist? If so, when and reason? _____

7. Are you currently being treated for any illness? If so please list? _____
8. Past Surgery (list all surgeries you've had performed, including non-foot procedures): _____

9. Please list all medications that you are currently taking: _____

10. ALLERGIES (Please list all & reaction type) _____

11. Do you participate in sports? If so please list type. _____

12. Do you smoke cigarettes? Yes , Number of Years _____ Packs per Day _____ No

13. Consume Alcohol? None Socially Frequently Past Alcohol Abuse

Medical History (Check the appropriate column)

	YES	NO		YES	NO
Anemia	_____	_____	Hepatitis (Type _____)	_____	_____
Arthritis	_____	_____	High Blood Pressure	_____	_____
Bleeding problems	_____	_____	HIV-AIDS	_____	_____
Blood Transfusion	_____	_____	Joint Replacement Surgery	_____	_____
Circulation problems	_____	_____	Kidney Problems	_____	_____
Cholesterol	_____	_____	Liver Problems	_____	_____
Diabetes (Type _____)	_____	_____	Pacemaker	_____	_____
Drug Dependency	_____	_____	Phlebitis	_____	_____
Epilepsy	_____	_____	Rheumatic Fever	_____	_____
GI Ulcers	_____	_____	Sickle Cell Anemia	_____	_____
Gout	_____	_____	Sickle Cell Trait	_____	_____
Heart Murmur	_____	_____	Stroke	_____	_____
Heart Trouble	_____	_____	OTHER: _____		

Family History (Check the appropriate column)

	YES	NO		YES	NO
Arthritis	_____	_____	Diabetes	_____	_____
Cancer	_____	_____	Heart Disease	_____	_____
Circulation Problems	_____	_____	OTHER: _____		

Consent

I hereby give permission to **Dr. Mitchell Kahn / Dr. S. Jeffrey Siegel / Dr. Steven M. Remus** to examine and administer treatment as may be deemed necessary in the diagnosis and/or treatment of my foot and/or ankle problem(s).

Signature

Date

Relationship to Patient (if patient is a minor) _____