

**RORY S. COHEN, DPM
& ASSOCIATES
PATIENT INFORMATION**



Patient's Name: _____ Today's Date: _____

Address: _____

APT#

City/State/ZIP: _____

Email: _____ Marital Status: _____

Home Phone: (____) _____ Work Phone: (____) _____ Cel Phone: (____) _____	Date of Birth: ____/____/____ Age: ____ Social Security #: _____ Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female
---	---

Place of Employment _____

Employment Address: _____

Work Telephone#: _____ EXT: _____

If not working are you a student?: No Yes, → if Yes Full Time Student Part Time student

Family Physician: Approximate **Date** you last saw you Primary Care Doctor? _____

Dr's Name: _____ Phone #: () _____

Dr's Address: _____ City/State/Zip _____

HEALTH INSURANCE INFORMATION

Primary Insurance: _____ _____	Secondary Insurance: _____ <input type="checkbox"/> Flexible Spending
--	--

How did you learn about our office? (Please give names & check all that apply)

- | | | |
|---------------------------------------|--|--------------------------------------|
| <input type="checkbox"/> Friend _____ | <input type="checkbox"/> Yellow pages | <input type="checkbox"/> Internet |
| <input type="checkbox"/> Doctor _____ | <input type="checkbox"/> Newspaper _____ | <input type="checkbox"/> Other _____ |

Did you have Previous PODIATRY CARE? Yes No

if yes, Dr's Name _____ Date _____

Treatment _____

ASSIGNMENT OF BENEFITS

FOR MEDICARE PATIENTS ONLY: YEAR 2009 DEDUCTIBLE is \$135.00

Please note when the Doctor is taking ASSIGNMENT, it means that you are responsible for **yearly deductible** and for the **20% (Co-Insurance)** of what Medicare allows. If you have co-insurance, you are also responsible for services that your co-insurance doesn't cover.

Unlike some offices, the **FILING OF INSURANCE CLAIMS** is a **COURTESY** that we have always extended to our patients. However, all charges are **YOUR** responsibility, **NOT YOUR Insurance Company's**. We will make our **BEST EFFORT** to collect from them, but if, despite our best efforts, we are **NOT SUCCESSFUL**, **YOU** are responsible for the unpaid balance.

We realize that temporary financial problems may affect timely payment of your account. We don't want any financial problems to get in the way of our good relationship with you. If such problems arise, we encourage you to contact us promptly for assistance in the management of your account.

C O N S E N T

I give permission to the doctor and associates or affiliates to administer and perform such procedures as may be deemed necessary in the diagnosis and/or treatment of my feet.

SIGNATURE ON FILE

1. I authorize use of this form on *all* my insurance submissions
2. I authorize release of information to all my *insurance companies*
3. I understand that *I am responsible* for my bill
4. I authorize my doctor to act as *my* agent in helping me obtain payment from my insurance companies
5. I authorize payment direct to my doctor
6. I permit a copy of this authorization to be used in place of the original

NAME _____
PLEASE PRINT

INSURANCE ID NO.: _____

SIGNATURE _____

DATE _____

Notice of Privacy Practices

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read if I so choose) and understood the Notice.

Signature

Date

NAME: _____

F M

D/O/B: ___/___/___

YOUR HEALTH HISTORY

1. Do you have any of the following medical conditions: (check all that apply)

- | | | |
|--|--|--|
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Psychological |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Kidney Problems | <input type="checkbox"/> Respiratory |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Hypercholesterolemia | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Gastrointestinal Problems | <input type="checkbox"/> Heart Attacks |
| <input type="checkbox"/> Other: _____ | | |

3. **ALLERGIES:**

- | | | |
|---|--|---------------------------------------|
| <input type="checkbox"/> Penicillin | <input type="checkbox"/> Codeine | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Sulfa Drugs | <input type="checkbox"/> Iodine/ Shellfish | _____ |
| <input type="checkbox"/> Local Anaesthetics | <input type="checkbox"/> Tape | |
| <input type="checkbox"/> Aspirin | <input type="checkbox"/> Antibiotics | |

4. **DO YOU USE:**

- CIGARETTES/TOBACCO
- ALCOHOL
- ILLEGAL DRUGS

5. Is there a family history of?

- | | | |
|--------------------------------------|--|--|
| <input type="checkbox"/> DIABETES | <input type="checkbox"/> KIDNEY | <input type="checkbox"/> SICKLE CELL |
| <input type="checkbox"/> CANCER | <input type="checkbox"/> HEART PROBLEM | <input type="checkbox"/> Foot Problems |
| <input type="checkbox"/> Other _____ | | |

6. **WHAT MEDICATIONS DO YOU CURRENTLY TAKE?**

7. **HAVE YOU EVER HAD SURGERY?** NO YES

IF YES, DATE AND TYPE OF SURGERY: _____

8. Have you ever been hospitalized? NO YES - if yes, when? _____

Reason: _____

9. **Foot Complaint:** _____
