Please complete and return this form
along with a copy of your insurance card
and fax it to: **973-256-3919**

MARC S. KITROSSER, D.P.M., P.A. PODIATRIC MEDICINE AND SURGERY

WELCOME TO OUR OFFICE

PATIENT LAST NAME: FIRST NAME:	BIRTH DATE: __/____/____ CURRENT AGE: ( )FEMALE ( )MALE
ADDRESS:	MARITAL STATUS: S M W D SOCIAL SECURITY #
CITY: STATE: ZIPCODE:	EMERGENCY CONTACT PERSON:
HOME TELEPHONE: CELLULAR NUMBER:	EMERGENCY CONTACT NUMBER:
PRIMARY INSURANCE:	SECONDARY INSURANCE:
PHARMACY NAME:	PHARMACY TELEPHONE:
CURRENT EMPLOYER: CURRENT EMPLOYER TELEPHONE:	PRIMARY DOCTOR: PRIMARY DOCTOR TELEPHONE:
WHAT IS THE REASON FOR YOUR VISIT TODAY:	
Referred By:	

MEDICAL-SOCIAL HISTORY

HAVE YOU EVER SUFFERED FROM ANY OF THE FOLLOWING:

	YES	NO		YES	NO
AIDS or other infectious Disease	___	___	Hepatitis or Liver Disease	___	___
Heart Condition	___	___	Bleeding Disorder or Anemia	___	___
High Blood Pressure	___	___	Ulcer or Digestive Disease	___	___
Stroke or Neurological Disease	___	___	Thyroid or gland Disease	___	___
Cancer	___	___	Circulatory Problems	___	___
Lung Disease	___	___	Do you Smoke?	___	___
Diabetes	___	___	Do you consume beer, wine, liquor?	___	___

If Yes, How Long? ___________ Last blood sugar: _______ Last Blood Pressure Result: __________

Height: ________ Weight: ________________

List **ALL** medications presently taking:

________________________________ ________________________ __________________________

________________________________ ________________________ __________________________

List any medical allergies:

____

Other Surgery, illness or hospitalization not noted above

____

Uniform Assignment and Release of Information Statement

I hereby assign or transfer payments made to me or on my behalf to Dr. Kitrosser for any services furnished to me by this physician. I further agree that I am responsible for payment of charges incurred by me that are outside of the scope of my insurance coverage or for which my insurance coverage has paid me. I hereby authorize Dr. Kitrosser to release information acquired during the course of my examination or treatment to my referring physician or to an appropriate insurance carrier. In the event of unpaid patient responsibility, patient will become liable for finance charges and any additional fees incurred in addition to the balance.

PATIENT SIGNATURE: ______________________________ DATE: ________________________