Patient Information	Date:		
Last Name:	First Name:		
DOB:/ Age:	Sex: M F Race/Ethnicity:		
Social Security Number:	Single [] Married [] Other:		
Address:	Apt #:		
City/State:	Zip:		
E-Mail Address:	Home Phone #: ()		
Work Phone #: ()	Cell Phone #: ()		
Emergency Contact:	Emergency Contact #: ()		
Are you Employed?[] None [] Fu	ıll time [] Part time [] Retired [] Student		
Employer:	Occupation:		
General Physician's name:	Date of last visit:		
	[] Yellow Pages [] Insurance [] Friend te [] Referral		
Do you have a "Flex Spending" or "I	HAS" type account: [] Yes [] No [] Unsure		
Insurance Information			
Insurance Company:			
Policy ID Number:	Group Number:		
Who is the policy holder? [] Self	[] Spouse [] Parent [] Step Parent [] Other		
Policy Holders: Last Name:	First Name:		
Policy Holders DOB://	_		
Policy Holders Social Security numb	er:		

	Patient Medical Histor	ry	
Name: Date:			
Please describe your curren	t foot problems:		
How Long have you had th	is problem?		
Describe the onset: [] Sudo	den []Gradual		
Since onset the problem has	s: [] Worsened [] Improved	I [] Not Changed	
Describe any treatment you	have had for this current prol	olem:	
Past Medical History Have you ever been DIAGNOSED with any of the following:			
[] Anemia [] AIDS [] Angina [] Anxiety Disorders [] Arthritis Osteo [] Arthritis Rheumatoid [] Asthma [] Bleeding Disorders [] Blood Clots [] Cancer [] Claustrophobia [] Depression [] Emphysema [] Fibromyalgia	[] Gout [] Gastro-Esophageal Reflux Disease (GERD) [] Heart Arrhythmia [] Heart Disease [] Hepatitis [] High Blood Pressure [] High Cholesterol [] HIV [] Kidney Disease [] Liver Disease [] Migraine Headaches [] Mitral Valve Prolapse [] Nervous Disorders	[] Stomach Ulcer	

List all past surgeries (not limited to feet)
MEDICATIONS AND ALLERGIES
Medications (Please list all current prescription and over the counter medications): [] NONE
Allergies: [] Adhesive Tape [] Aspirin [] Codeine [] Iodine [] Latex [] Local Anesthetic [] Malignant Hyperthermia [] Metal [] Penicillin [] Sulfa [] Other
Reactions:
Do you smoke? [] No [] Yes
Do you drink alcohol? [] No [] Ye s Frequency: Occasionally/Frequently/Rarely (Circle One)
Does your family have a history of foot problems? [] No [] Yes
Have you ever experience any of the following problems with your feet:
[] Burning [] Coldness [] Cramping [] Dryness [] Excessive Sweating [] Weakness [] Numbness [] Pain [] Redness [] Swelling [] Ulcers [] Itchiness [] Other [] NONE
<u>Consent:</u>
I certify that the above information is true and correct to the best of my knowledge. I give my permission to the doctor to administer and perform such as may be deemed necessary in the diagnosis and/or treatment of my feet.
Patient's Signature:Date:

Michael P. Nagelberg, DPM 360 Ninth Street, Brooklyn, NY 11215 Tel (718) 768 – 4529 Fax (718) 768 – 0595

Assignment of Benefits

I hereby assign any rights I may have under my insurance agreement to the extent necessary for the facility to recover any medical expense benefits due to me.

I certify that my policy is active on the date of service and my assignment of benefits is accepted by my doctor at the Park Slope Podiatry.

If any payments are made directly to the policy holder (you), all payments and accompanying Explanations of Benefits (EOB) are required to be transmitted immediately to me.

If you do not promptly comply with our office protocol, I will have no other alternative but to bill you directly and in full for services provided to you. Please forward all payments and correspondence to the above address:

Patient Name (Please Print)	
Signature	
Date	
Date	

If applicable, please complete:

Medicare Authorization:

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Park Slope Podiatry, P. C., for any services furnished me by that physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature request that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HFCA-1500 form, or else were on the other approved claims forms or electronically submitted claims, my signature authorizes releasing of the information to the insure or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance and non-covered service. Co-insurance and the deductible are based upon the charge determination of the Medicare carrier.

Beneficiary Signature:	 Date:

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Signature on File

- 1. I authorize the use of this form with my insurance claim submission.
- 2. I authorize the release of my personal and medical information to all my insurance companies.
- 3. I authorize the doctor to act as my agent in helping me obtain information from my insurance companies.
- 4. I authorize that the insurance companies make direct payment to my doctor.
- 5. I permit a copy of this authorization to be used in place of the original.

Print Name:	 	 	
Signature:	 	 	
Date:			

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RECEIPT OF NOTICE OF PRIVACY PRACTICES WRITTEN ACKNOWLEDGEMENT FORM

I,	have received a copy of the	e Patient Privacy Practice.
(Patient Name/Please Pri	nt)	
(Signature of Patient or L	egal Guardian)	(Date)