EUGENE M. ROSENTHALL, DPM, FACFAS
4500 EAST 9TH AVENUE, STE 510
DENVER, COLORADO 80220
303-333-6556

PERSONAL INFORMATION:

Patient's Name____ SS#__________________ Birth Date____________________ Age____

Address____ City_____________________ State________ Zip___________________

Home Phone___________________________ Cell Phone___________________________ Work Phone___________________________

Employer____ Occupation____

Address____ City_____________________ State________ Zip___________________

Email____ Pharmacy/Location____

Emergency Contact Name______________________________ Emergency Contact Phone _____________________________________

Referred By___________________________________ ❑Physician ❑Patient ❑Hospital ❑Insurance Co ❑Internet ❑Urgent Care

Marital Status: ❑Married ❑Single ❑Widowed ❑Divorced ❑Other
Race: ❑American Indian/Alaska Native ❑Asian ❑Hawaiian or Other Pacific ❑Black/African American ❑White ❑Other
Ethnicity: ❑Hispanic or Latin ❑Non Hispanic or Latin ❑Other:___________________________
Language: ❑English ❑Spanish ❑Russian ❑Other:_______________________________________

INSURANCE POLICY HOLDER:

Name____ SS#___________________________ Birth Date____________________________

Address_____________________________________ City___________________ State______ Zip_________ Phone (H)_____________

Employer____________________________________ Relationship____

INSURANCE INFORMATION:

Primary Insurance Company ____

Secondary Insurance Company ____

Workman's Compensation/Automobile Claim Number ____

RELEASE OF INFORMATION: I give permission to Eugene Rosenthall, DPM, PC to relay my medical information to my emergency contact.

PAYMENT POLICY: Payment is due at the time of service. Your insurance is a contract between you in your insurance company. While we cannot guarantee that your insurance company will pay your claim, we will provide information to them if requested and the data is accurate and complete.

MEDICAL HISTORY: I give permission to Eugene Rosenthall, DPM, PC to obtain my medical history and medications from my physicians and pharmacies.

INSURANCE AUTHORIZATION AND ASSIGNMENT: I hereby authorize treatment of the above patient. I hereby authorize Eugene M. Rosenthall, DPM, PC to furnish information to insurance carriers regarding my illness and treatments, and I hereby assign to the physician(s) all payments for medical services rendered to myself and my dependents. I understand that I am responsible for any **CO-PAYMENTS, DEDUCTIBLES OR BALANCES** not covered by my insurance. I agree and understand that if I do not pay any balances owed in a timely fashion, I will be responsible for paying the collection fee of 30% of the principal balance due at the time the account is turned over to a professional collection agency including all reasonable attorney fees.

NOTICE OF PRIVACY PRACTICE: I acknowledge that I have been given an opportunity to review the Notice of Privacy Practices. At this time I have no further questions regarding the Notice of Privacy Practices.

Patient Signature: ____Date: ____

My Family Physician Is: ____

MEDICAL HISTORY

MAJOR DISEASES
- ❑Diabetes – Type I
- ❑Diabetes – Type II
- ❑High Blood Pressure
- ❑Hyperthyroid
- ❑Hypothyroid
- ❑Heart Disease
- ❑Heart Attack
- ❑Atrial Fibrillation
- ❑Arrhythmia
- ❑Murmur
- ❑Mitral Valve Prolapse
- ❑Stroke
- ❑Chest Pain
- ❑High Cholesterol

VASCULAR
- ❑ Anemia
- ❑ Sickle Cell/Trait
- ❑ Bleeding Disorder:____________
- ❑ Poor Circulation
- ❑ Varicose Veins
- ❑ Leg Ulceration
- ❑ Blood Clots
- ❑ Transfusions

RESPIRATORY
- ❑ Asthma
- ❑ Bronchitis
- ❑ COPD
- ❑ Shortness of Breath
- ❑ Tuberculosis
- ❑ Emphysema

GASTROINTESTINAL
- ❑ Ulcers
- ❑ Hiatal Hernia
- ❑ GI or Rectal Bleeding
- ❑ Acid Reflux (GERD)
- ❑ Celiac
- ❑ Irritable Bowel Syndrome
- ❑ Ulcerative Colitis

HEENT
- ❑ Headaches
- ❑ Glaucoma
- ❑ Cataracts
- ❑ Hearing Loss

ARTHRITIS
- ❑ Osteoarthritis
- ❑ Rheumatoid
- ❑ Gout

MISCELLANEOUS
- ❑ Osteopenia
- ❑ Osteoporosis
- ❑ Epilepsy
- ❑ Kidney Problems:____________
- ❑ Bladder Problems:____________
- ❑ Prostate Problems:____________
- ❑ Cancer History:______________
- ❑ Hepatitis
- ❑ HIV
- ❑ Fibromyalgia
- ❑ Seasonal Allergies

PSYCHOLOGICAL
- ❑ Anxiety
- ❑ Depression
- ❑ Bipolar Disease
- ❑ Drug Dependence
- ❑ Alcohol Dependence

OTHER ILLNESSES

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____
____
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MEDICATION LIST

______________________ ______________________ ______________________ ______________________
______________________ ______________________ ______________________ ______________________
______________________ ______________________ ______________________ ______________________
______________________ ______________________ ______________________ ______________________

PAST SURGICAL HISTORY

Surgery	**Date**
______________________	______________________
______________________	______________________
______________________	______________________
______________________	______________________

SOCIAL HISTORY

Alcohol__________ ❑ Drinks Per Day ❑ Drinks Per Week

Tobacco__________ Packs Per Day For _______Years

❑ ***Former Smoker***

Marijuana Use: ❑ Yes ❑ No

Are You Pregnant or Possibly Pregnant? ❑Yes ❑No ❑Unsure
Are You Currently Breast Feeding? ❑Yes ❑No

FAMILY HISTORY

	Father ❑ Alive ❑Deceased	**Mother** ❑ Alive ❑Deceased	**Sibling(s)** ❑ Alive ❑Deceased
High Blood Pressure			
Diabetes			
Stroke			
Cancer			
Other			

ALLERGIES

❑I Am Not Allergic To Any Medications (NKDA)

❑Penicillin ❑Codeine ❑Sulfa Drugs
❑Aspirin ❑Latex ❑Tape
❑Shell Fish ❑Local Anesthetics
❑Iodine ❑General Anesthetics
❑Other:____________________________