FORT HAMILTON FAMILY FOOT CARE

FOOT AND ANKLE SPECIALISTS

DR. LUIS MONTALVO, D.P.M., D.A.B.P.S.

DATE:______________________________ REFERRED BY: ____________________________________

IN ORDER TO SERVE YOU PROPERLY, WE NEED THE FOLLOWING INFORMATION.

ALL INFORMATION IS STRICTLY CONFIDENTIAL.

PLEASE REFER TO OUR PRIVACY POLICY FOR MORE DETAILS.

PATIENT'S NAME:____ BIRTHDATE:________________

MARITAL STATUS: ____________________________

ADDRESS:____ APT: ______________________

CITY:____ STATE:_______ ZIP:_________

HOME PHONE: ______________________________ MOBILE/WORK PHONE: ____________________________

EMPLOYER: _______________________________ ADDRESS:_____________________________________

NAME OF SPOUSE OR PARENT: ____________________________Tel #________________________________

EMAIL:

CHIEF COMPLAINT/ REASON FOR VISIT: ____

____

DO YOU HAVE ANY MEDICAL CONDITIONS?____

PLEASE LIST ANY MEDICATIONS YOU ARE TAKING: ____

LIST ANY ALLERGIES TO MEDICATIONS OR DRUGS?____

LIST ANY ALLERGIES TO FOOD, FISH, IODINE, HAY FEVER, ETC: _______________________________

HAVE YOU HAD ANY SURGERIES IN THE PAST?____

NAME OF PRIVATE MEDICAL DOCTOR:____

PHARMACY NAME &
ADDRESS____

PRIMARY INSURANCE COMPANY: ___________________________POLICY NUMBER: ___________________

POLICYHOLDER/INSURED NAME: ____________________________SSN#: ______________________________

DO YOU HAVE ANY SECONDARY INSURANCE? ____

ID# ____ GROUP# ______________________________________

I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES FOR SERVICES RENDERED TO ME. I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO MYSELF, OR THE DOCTORS TREATING ME. I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS THIS CLAIM. I ACKNOWLEDGE THAT I HAVE RECEIVED A COPY OF LUIS MONTALVO D.P.M.'S NOTICE OF PRIVACY PRACTICES. THIS NOTICE DESCRIBES LUIS MONTALVO, D.P.M. MAY USE AND DISCLOSE MY PROTECTED HEALTHCARE INFORMATION, AND RIGHTS I MAY HAVE REGARDING PROTECTED HEALTH INFORMATION.

PATIENT SIGNATURE: ____ DATE: ______________

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