PATIENT INFORMATION

Date: ____

Last Name: ____________________________________

First Name: __________________________ **M.I.:** ______

Address: ______________________________________

____

City: ____

State: __________________________ **Zip:** ___________

Birth date: ________/______/_________ **Age:** _________

Sex: Male Female

Social Security: ____________-_________-____________

E-mail: _______________________________________

Home Phone: (___________) _______________________

Work Phone: (___________) ________________________

Cell Phone: (___________) _________________________

Marital Status: Married Widowed Single

Separated Divorced

How did you hear about our practice?

Doctor Referral Health Fair Internet Friend/Family

Yellow Pages Newspaper

Other: ____

Primary Care Physician: ___________________________

____

Are you diabetic? Yes No

If yes, name of physician managing diabetes

____

Employed: Full Time Part Time None

Employer: ____________________________________

INSURANCE

PRIMARY

Insurance Company: _____________________________

Insurance ID Number: ____________________________

Insurance Group Number: _________________________

Subscribers Name: ______________________________

Subscribers Birth Date: ________/________/__________

Subscribers SS#: ____________-__________-___________

Relationship to Patient: ___________________________

SECONDARY

Insurance Company: _____________________________

Insurance ID Number: ____________________________

Insurance Group Number: _________________________

Subscribers Name: ______________________________

Subscribers Birth Date: ________/________/__________

Subscribers SS#: ____________-__________-___________

Relationship to Patient: ___________________________

INSURANCE ASSIGNMENT AND RELEASE

I certify that I have insurance coverage with above-named insurance and assign directly to Svetlana Malinsky, D.P.M, P.C. all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named doctor may use my health care information and may disclose such information to the above-named insurance Company(ies) and their agents for the purpose of obtaining payment for services.

MEDICARE/MEDIGAP AUTHORIZATION

I request that payment of authorized Medicare benefits and, if applicable, Medigap benefits, be made to me or on my behalf to Svetlana Malinsky D.P.M., P.C. for any services furnished to me by that provider.

To the extent permitted by law, I authorize any holder of medical or other information about me to release to the Centers for Medicare and Medicaid Services, my Medigap insurer, and their agents any information needed to determine these benefits for related services.

_______________________________ ___________________

PATIENT/GUARDIAN SIGNATURE DATE

MEDICAL FORM

REASON FOR YOUR VISIT:

What is the chief complaint for which you came to be treated? ____

____

MEDICAL HISTORY: (Check all that apply)

AIDS/HIV___	Diabetes___	High Blood Pressure___	Stomach Ulcers___
Anemia___	Epilepsy___	High Cholesterol___	Thyroid problems___
Arthritis___	GERD___	Kidney Disease___	Valve/Joint replacement___
Asthma___	Gout___	Liver Disease___	Varicose veins___
Bleeding problem___	Heart Disease___	Phlebitis___	Other _________________
Cancer___	Hepatitis___	Stroke___	

CURRENT MEDICATIONS:

______________________________ ______________________________ ______________________________

______________________________ ______________________________ ______________________________

______________________________ ______________________________ ______________________________

______________________________ ______________________________ ______________________________

HAVE YOU EXPERIENCED…

	YES NO		YES NO
Back problems	___ ___	Headaches	___ ___
Burning, tingling or numbness in toes	___ ___	Itchy skin on feet	___ ___
Dryness of skin	___ ___	Reaction to local anesthetic	___ ___
Episodes of Fainting	___ ___	Shortness of breath	___ ___
Foot/leg cramps while sleeping	___ ___	Swelling of Feet/Ankles	___ ___
Foot/Leg cramps while walking	___ ___	Keloid or thick scars	___ ___

ALLERGIES (Check all that apply)

Adhesive/Tape ____	Iodine ____	Penicillin ____
Anticoagulant Therapy ____	Latex ____	Seafood's ____
Aspirin ____	Local Anesthetics ____	Sulfa ____
Codeine ____	Novocaine ____	Other ______________
Demerol ____		

SURGICAL HISTORY (Procedure and year) ____

____

SOCIAL HISTORY:

SMOKING:

Do you or have you ever smoked? YES NO

If yes, how many years? ____ How long ago did you quit? ____

ALCOHOL USE:

Do you or did you ever drink alcoholic beverages? YES NO

How many drinks will you consume in a day? ____ Week? ____

How long ago did you quit? __________________________

RECREATIONAL DRUG USE:

Do you or have you ever used illicit/recreational drugs? YES NO

If yes, which ones? ___________________________________

How long ago did you quit? ____________________________

Women: Are you currently pregnant? YES NO

Due Date? ____

CONSENT FOR TREATMENT

I certify that the information above is true and correct to the best of my knowledge. I hereby consent and give my permission to the doctor (and the doctor's assistants or designated replacement) to administer and perform such procedure upon me as the doctor deems necessary.

____ ______________________________________

Signature of Patient, Parent, Guardian or Personal Representative Date