WELCOME TO OUR OFFICE – **Jeffrey A. Marks, DPM, PC**

161 Old Schoolhouse Lane, Suite 2, Mechanicsburg, PA 17055 (717)697-7602

PATIENT INFORMATION

Name _____

Address _____ City/State/Zip _____

Telephone: _____ Mobile: _____ Email: _____

Date of Birth _____ Age _____

Employer Name: _____ Work Telephone _____

Emergency Contact Name: _____ Telephone: _____

INSURANCE INFORMATION

Please fill out this information

We will make a copy of your insurance card(s) for the policy numbers and other information we may need for claim submission. However, please fill out the spaces below to help clarify information not on your card:

Primary Insurance Co. _____ ID Number _____

Subscriber's Name: _____ Relationship: _____ Date of Birth _____

Secondary Insurance Co. _____ ID Number _____

Subscriber's Name: _____ Relationship: _____ Date of Birth _____

REFERRAL

How did you hear about our office? ☐ Doctor _____

☐ Yellow Pages ☐ Internet ☐ Another Patient ☐ Provider Directory ☐ Walk In

CHIEF COMPLAINT

Briefly describe the chief complaint that brought you to our office: _____

_____

MEDICAL HISTORY

Family Physician _____ Last Visit _____

Preferred Pharmacy _____

Do you, or did you ever, have:

	Yes	No		Yes	No		Yes	No		Yes	No
High Blood Pressure	☐	☐	Hepatitis	☐	☐	Blood Clots	☐	☐	Cancer	☐	☐
Heart Attack	☐	☐	Kidney Stones	☐	☐	Arthritis	☐	☐	Diabetes	☐	☐
Heart Failure	☐	☐	Stroke	☐	☐	Seizures	☐	☐	Phlebitis	☐	☐
Kidney Infections	☐	☐	Emphysema	☐	☐	Gastric Ulcers	☐	☐	Hiatal Hernia	☐	☐
Thyroid Problems	☐	☐	Liver Disorder	☐	☐	Asthma	☐	☐	Depression	☐	☐
Fibromyalgia	☐	☐	GERD	☐	☐	Auto Imm.	☐	☐	Anxiety	☐	☐

Type: _____

Any other serious illnesses? _____

_____

MEDICATIONS

Include prescriptions, over-the-counter, supplements (Please include dosages):

_____

_____

_____

ALLERGIES and REACTIONS

Adhesive Tape ☐ Local Anesthetics ☐ Penicillin ☐ Sulfa ☐ Iodine ☐ Other: _____

SURGICAL HISTORY AND DATES

Please list surgeries you have had: _____

_____

FAMILY HISTORY

Have any members of your family been treated for any of the following:

	Yes	No	WHO?		Yes	No	WHO?
Diabetes	☐	☐	_____	Bleeding Disorders	☐	☐	_____
Cancer	☐	☐	_____	Heart Disease	☐	☐	_____

SOCIAL HISTORY

	Yes	No	
Do you smoke?	☐	☐	How much? _____
Do you drink alcohol?	☐	☐	How much? _____
Do you use any recreational drugs?	☐	☐	What type? _____

CONSENT

ASSIGNMENT AND RELEASE: I, the undersigned, certify that I, or my dependent have insurance coverage with the previously named carrier(s) and assign directly to Dr. Marks all insurance benefits for services furnished by him. I understand that I am financially responsible for all charges whether or not paid by insurance for all services rendered on my behalf or my dependents. I authorize any holder of hospital or medical information about me to be released if needed to determine the benefits payable for related services. I permit a copy of this authorization to be used in place of my original signature. If for any reason this account is sent to collections, I will be responsible for any fees associated with collecting the balance due on the account.

Signature of Responsible Party_____ Date: _____

MEDICARE AUTHORIZATION

I request that payment of authorized Medicare benefits be made directly to Dr. Marks for any services furnished on my behalf by him. 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 requests 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 CMS-1500 form or in electronically submitted claims, my signature authorizes releasing information to the insurer 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 for the deductible, coinsurance, and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

Beneficiary Signature _____ Date _____ _____