Welcome To Our Practice

Patient Information

How did you find our practice? ______________________ Today's Date:_______________

Patient:____ Patient's SS#:____________________________

Address:____ Marital Status: S - M - D - W - Sep (circle one)

Minor/Dependant

____ Sex: M / F

City State Zip

Birth Date:_________________ Age:___________ Emergency Contact:_____________________

Phone: Home:______________________Cell:______________________ Phone: Home:________________ Cell:________________

Work:______________________ Work:____________________

Best time and place to reach you: ___________________ Relationship to Patient:___________________

Insured's Information

Who will be responsible for payment of deductibles and co-payments? ______________________________
* Please note that in the case of minors and/or divorces, **the parent or guardian <u>requesting care</u> is ALWAYS the responsible party.**

Insured's Name:___________________________________ Insured's SS#:___________________________

Address:____ Marital Status: S - M - D - W - Sep (circle one)

____ Insured's Phone: ________________________

City State Zip

Birth Date:_________________ Age:___________ Sex: M / F

Primary Insurance Co:______________________________ Relationship to Patient:___________________

Secondary Insurance Co:___________________________ Employer:__________________________________

Authorization for Insurance Payment

I hereby assign payment of insurance benefits directly to Dr. Eric Trattner. I request that payment of authorized Medicare/Insurance benefits be made on my behalf to Dr. Eric Trattner for any and all services provided. I further authorize the release to the Health Care Financing Administration and its agents personal and medical information about me/my child required to determine benefits payable for related services. I understand that my signature requests that payment be made and authorizes release of medical information necessary to pay the claims.

I also understand that by requesting medical care for myself/my child <u>I am personally responsible</u> for the balance on this account, regardless of insurance coverage, and subject to insurance deductibles and/or co-payments.

____
Signature

Podiatric History

What is your primary foot problem for which you are requesting treatment today? ______________________

____

Your Occupation______________________________

Athletic Activities/Frequency:______________________

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Height: ______________ Weight: ______________

Have you ever seen a Podiatrist before? Y / N

Reasons: ______________________________

Name:________________ Last Visit:________

Is there a family history of Diabetes? Y / N

Who?________________________

Do you use tobacco? Y / N

Medical History

Please indicate if you have had any of the following:

AIDS/HIV	Y / N	Chronic Diarrhea	Y / N	Hepatitis or Jaundice	Y / N	Special Diet	Y / N
Anemia	Y / N	Circulatory Problems	Y / N	High Blood Pressure	Y / N	Stroke	Y / N
Angina	Y / N	Diabetes	Y / N	Kidney Problems	Y / N	Swelling of Feet or Ankles	Y / N
Arthritis	Y / N	Ear Problems	Y / N	Liver Disease	Y / N	Swollen Neck Glands	Y / N
Artificial Heart Valves or Joints	Y / N	Epilepsy	Y / N	Low Blood Pressure	Y / N	Tired Feet	Y / N
Asthma	Y / N	Eye Problems	Y / N	Phlebitis or Blood Clots	Y / N	Tuberculosis	Y / N
Back Problems	Y / N	Fainting	Y / N	Psychiatric Care	Y / N	Ulcers	Y / N
Bleeding Disorders	Y / N	Foot or Leg Cramps	Y / N	Rashes	Y / N	Varicose Veins	Y / N
Cancer	Y / N	Gout	Y / N	Respiratory Disease	Y / N	Venereal Disease	Y / N
Chemical Dependency	Y / N	Headaches	Y / N	Rheumatic Fever	Y / N	Weight Loss Unexplained	Y / N
Chest Pain	Y / N	Heart Disease	Y / N	Shortness of Breath	Y / N		
		Hemophilia	Y / N	Sinus Problems	Y / N		

Surgeries or hospitalizations:______________________

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Primary Physician: ____________________________

Physician's Address:___________________________

Telephone:____________________________

Date Last Seen:__________

Medications

Please list any medications you take daily. Include any supplements.

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Do you take Oral Contraceptives? Y / N

Allergies

List any other allergies to medications, foods or fabrics. Include type of reaction:

Adhesive/Tape	Y / N	Latex	Y / N
Anticoagulant Therapy	Y / N	Local Anesthetics	Y / N
Aspirin	Y / N	Novocain	Y / N
Codeine	Y / N	Penicillin	Y / N
Demerol	Y / N	Seafood	Y / N
Iodine	Y / N	Sulfa	Y / N

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Pharmacy:____________________________ Address: ____________________________________

Phone:______________________________ ____________________________________

Consent for Treatment

I certify that the above information is true and correct to the best of my knowledge. I give my permission to Dr. Eric Trattner and his staff to administer and perform such procedures as may be deemed medically necessary in the diagnosis and/or treatment of my feet.

Patient/Guardian: ____ Date: ______________

Patient Record of Disclosures

In general, the HIPPA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

I wish to be contacted in the following manner (check all that apply):

[ ] **Home telephone**______________________

[ ] Okay to leave message with detailed information

[ ] Leave message with call-back number only

[ ] **Work telephone**________________________

[ ] Okay to leave message with detailed Information

[ ] Leave message with call-back number only

[ ] **Written communication**

[ ] Okay to mail to my home address

[ ] Okay to mail to my work/office address

[ ] Okay to fax to this number_________________

[ ] **Other contacts: List family members if any:**

____

____

____

____

____ Patient's name (please print)

____________________ Birth date

____ Signature (patient/parent/guardian)

____________________ Date

THE PATIENT IS RESPONSIBLE FOR PROVIDING ANY CHANGES TO THIS FORM.

Authorization and Consent to Use and Disclose Medical Information

The Notice of Privacy Practices of Dr. Eric Trattner provides information about how we may use and disclose confidential information about you. Please read out Notice before signing this consent. The terms of our notice may change from time to time. If we change our Notice, you may obtain a revised copy during your next visit.

By signing this Authorization, you agree to let us use and disclose confidential medical information about you for treatment, payment and health care operations. This includes information about your physical and mental illness, substance abuse or HIV/AIDS, if applicable. You are also consenting to the release of medical information about you to any insurer, third party payer, the Social Security Administration, or ant agents or consultants who help this office obtain payment for your treatment as well as other health care operations.

____ Patient Signature

______________________ Date