HEALTHY FEET PODIATRY

LEO S. KRAWETZ, DPM,FACFAS
TODD J. BRENNAN, DPM

PATIENT INFORMATION PLEASE PRINT CLEARLY DATE_____

Patient Last Name First Name Int

_____

Street Address 1:_____
Street Address 2:_____

City:_____ **State:**_____ **Zipcode**_____

Home Number:_____ **Work Number:**_____

Employer:_____ **Sex: M/F**_____

Date of Birth:_____ **Social Security Number**_____

Marital Status_____

Emergency Contact Info Relationship to you Phone #

_____

Primary Care Physician:_____
How did you hear of us_____
Primary Insurance Name

_____

Address:_____

ID#_____**Group#**_____**Phone #**_____

Policy Holder Name Date of Birth Social Security number

_____

Please be advised that all uncovered charges are due at the time of service. We accept both MasterCard and Visa for your convenience. IF YOU NEED ASSISTANCE FILLING OUT THIS FORM DO NOT HESISTATE TO ASK!

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TODD BRENNAN, DPM

PATIENT NAME_____

PLEASE LIST THE PROBLEM THAT BRINGS YOU IN TODAY:_____

_____

_____

ONSET: Gradual___ Sudden___ Duration:___Days___Weeks___Months___Years
INJURY:_____ **TYPE OF PAIN**_____
PREVIOUS TREATMENT:_____
WHAT TYPE OF SHOES DO YOU NORMALLY WEAR:_____
PLEASE MARK ANY OF THE FOLLOWING MEDICAL CONDTIONS THAT YOU HAVE EVER HAD:

Diabetes_____ Ulcers_____ Rheumatic Fever_____
Cardiac_____ Cancer_____ Phlebitis _____
Hypertension_____ TB_____ Bleeding Disorder_____
Arthritis_____ Stroke_____ HIV/AIDS_____
Epilepsy_____ Asthma_____
Gout_____ Kidney_____
Nervous Disorders_____ Liver_____
Other_____

_____

LIST ANY MEDICATIONS YOU ARE TAKING ON A REGULAR BASIS

_____

_____

_____

MARK ANY OF THE FOLLOWING SURGERIES YOU HAVE HAD:

Tonsils_____ Gallbladder_____ Gastric_____
Appendix_____ Foot_____ Rectal_____
Hernia_____ Female_____ Injuries & Fractures_____
Other_____

ARE YOU ALLERGIC TO ANY OF THE FOLLOWING:

Penicillin_____ Aspirin_____ Codeine_____
Local Anesthetics_____ Iodine_____ Latex_____
Other_____

LIST ANY BLOOD RELATIVES WITH THE FOLLOWING CONDITIONS:

Diabetes_____ Foot_____
Gout_____
Other_____

DO YOU USE TOBACCO PRODUCTS:_____
Do you drink alcohol_____ How many drinks ___/day ___/week

CONSENT FOR:_____
(PRINT NAME OF PATIENT

The signature affixed below authorizes examination and treatment by Dr. Leo Krawetz or Dr Todd Brennan.

INSURANCE BILLING:

Please be aware that there are many different insurance policies, and as the insured, it is your responsibility to be aware of your policy requirements. For instance, some managed care policies require an authorization from a Primary Care Physician in order to be seen by a Specialist. Please present authorizations and referrals to the receptionist when you complete your New Patient Information.

My signature below authorizes payment to this office from any and all insurance carriers for medical expenses incurred. Photocopies of this form will be valid as the original. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

I accept responsibility to pay any deductible amount, con-insurance, or co-pay that my insurance dictates

MEDICARE/MEDIGAP
I certify that the information given by me in applying for payment under Title XVII or the Social Security Acts is correct. I authorize any holder of medical or other information about me to release to the SSA or its intermediaries or carriers any information needed for this or a related Medicare claim. I request that the payment of authorized benefits be made on my behalf. I assign the benefits payable for physician services to the physician and authorize the physician to submit a claim to Medicare for me.

I request that payment of authorized Medigap benefits be made on my behalf to this Practice for any services furnished me by a physician in the Group. I further authorize any holder of medical information about me to release to my Medigap Insurer any information needed to determine these benefits or the benefits payable for the related services.

PRIVATE PAY
I accept responsibility to pay all charges incurred as a result of treatment by the Physicians in the Group at the time of service.

_____
PATIENT OR LEGAL GUARDIAN SIGNATURE

DATE:_____

Healthy Feet Podiatry

Authorization to Share Protected Health Information

Patient Name

I authorize the physicians and staff of:

Healthy Feet Podiatry

To share protected health information with the following persons:

_____ Relationship_____

_____Relationship_____

_____Relationship_____

This includes (please check all areas that apply)

- All Medical Information
- Lab Results
- Medication RX renewal & Pickup
- Telephone Consults
- Insurance Information
- Appointment Information
- Other (please specify

This authorization will be in effect until authorization is revoked.

Patient's signature_____ Date_____

ACKNOWLEDGMENT OF RECEIPT

OF

NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read if I chose) and understood the Notice.

_____ _____

Patient Name (please print) Date

_____

Patient or Authorized Representative

HEALTHY FEET PODIATRY

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TODD BRENNAN, DPM

WAIVER OF NON-COVERED SERVICES

PLEASE BE AWARE THAT SOME INSURANCES DO NOT COVER CERTAIN PROCEDURES, DURABLE MEDICAL EQUIPMENT AND OVER THE COUNTER ITEMS THAT CAN BE DISPENSED IN OUR OFFICE.

YOUR DOCTOR WILL ALWAYS MAKE YOU AWARE THAT A SERVICE OR DISPENSED ITEM IS NON-COVERED.

TRIMMING OF CORNS, CALLOUSES AND NAILS IN A NON-DIABETIC MAY NOT BE COVERED BY SOME INSURANCES.

EXAMPLES OF DURABLE MEDICAL EQUIPMENT:

CUSTOM MADE ORTHOTICS, ARCH SUPPORTS, SURGICAL SHOES, AND HEEL CUPS.

EXAMPLES OF OVER THE COUNTER ITEMS:

WART OR FUNGUS MEDICATIONS, TOE AND FOOT PADS.
PERSONAL ITEMS SUCH AS CREAM AND LOTIONS.

ALWAYS ASK YOUR DOCTOR OR MEMBER OF THE STAFF IF YOU HAVE QUESTIONS ABOUT YOUR TREATMENT OR PROCEDURES.

PATIENT SIGNATURE **DATE**