

PATIENT NAME _____ BIRTHDATE _____ AGE _____ SEX M / F
 ADDRESS _____ CITY _____ ZIP CODE _____
 RESIDENCE PHONE _____ CELL/WORK _____ E-MAIL _____

(IF MINOR) FATHER'S NAME _____ MOTHER'S NAME _____

PATIENT'S SOCIAL SECURITY NO. _____ MARITAL STATUS _____ RACE _____

PATIENT OCCUPATION _____ EMPLOYER _____

INSURED NAME _____ INSURED BIRTHDATE ____/____/____

FAMILY PHYSICIAN _____ PHONE # _____

PHARMACY _____ LOCATION _____ # _____

HEIGHT _____ WEIGHT _____ (YES, FILL THIS IN) SHOE SIZE _____

REASON FOR VISIT TODAY _____

MEDICATION ALLERGIES _____

FOOD ALLERGIES _____ LATEX ALLERGY Y / N

PLEASE LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING INCLUDING NON-RX AND HERBAL SUPPLEMENTS

NAME	DOSAGE	NAME	DOSAGE

HAVE YOU EVER HAD OR CURRENTLY HAVE ANY OF THE FOLLOWING? (PLEASE CHECK):

- ABNORMAL BLEEDING ACID REFLUX ANEMIA ARTHRITIS
- ASTHMA/EMPHYSEMA BACK PROBLEMS BLOOD CLOTS CANCER
- CIRCULATION PROBLEMS CHOLESTEROL DIABETES DISABLED
- EPILEPSY FIBROMYALGIA FRACTURES GOUT
- HEART ATTACK HEART DISEASE HEPATITIS HIV/AIDS
- HYPERTENSION KIDNEY DISEASE LIVER DISEASE NEUROPATHY
- OPEN SORES PREGNANCY PHELBITIS STROKE
- THYROID PROBLEM OTHER _____

FAMILY MEDICAL HISTORY _____

PAST SURGERIES: APPENDIX BREAST CANCER HERNIA HYSTERECTOMY KNEE THYROID TONSILS
 TUBAL OTHER _____

ALCOHOL USE: NEVER QUIT SOCIAL RARE DAILY _____ DRINKS/DAY

CAFFEINE USE: NEVER SELDOM DAILY _____ CUPS/DAY

DRUG USE: NEVER QUIT USE MARIJUANA COCAINE IV DRUGS

TOBACCO USE: NEVER QUIT SOCIAL DAILY _____ PACKS/DAY _____ YEARS

IF YOU ARE DIABETIC: Are you currently under a comprehensive Diabetic treatment plan? Y / N

LAST BLOOD SUGAR _____ LAST A1C _____ DATE OF LAST PCP VISIT _____

"I understand that insurance claims may be submitted to my insurance carrier on my behalf, however, I accept full financial responsibility for these claims regardless of my insurance company actions."

(Date)

(Patient or Guardian Signature)

MEDICARE

(Name of Beneficiary)

(Health Insurance Claim No.)

"I request that payment of authorized Medicare benefits be made either to me or on my behalf to Rodney M. Kosanovich, D.P.M. for any services furnished to me by that physician or supplier. 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."

MEDIGAP

(Name of Beneficiary)

(Date)

(Beneficiary Signature)

(Date)

"I request that payment of authorized Medigap benefits be made either to me or on my behalf to Rodney M. Kosanovich D.P.M. for any services furnished me by that physician/supplier. I authorize any holder of Medicare information about me to release to _____ any information needed to determine these benefits payable for related services."

(Beneficiary Signature)

(Date)

PRIVACY NOTIFICATION

I, _____, give permission to Dr. Kosanovich /Dr. Scanlan/Dr. Collings and associates to leave information on an answering machine. I understand this may pertain to medical information.

Signature

Date

I also give permission for the following people to be given information, please circle all that apply

Spouse Mother Father Children Grandparents Other, please list names _____

MEDICAL RECORD POLICY

I/We understand that all of my medical information collected including office notes, lab testing, and x-rays are the property of Ankle and Foot Centers of Pittsburgh. I/We understand that I/We have the right to obtain a copy of all medical records in the possession of Ankle and Foot Centers of Pittsburgh in compliance with HIPAA regulations however, a written request must be presented to the office at least 5(five) days in advance of disbursement. Since we do not have the capabilities of copying x-rays, they will only be mailed directly to the medical office you have an appointment with. I/We also understand and agree to pay for all costs associated with copying the requested medical records prior to disbursement.

Patient Name

Signature

Date