Todays Date: _____

Primary Physician Name & Phone Number: _____

Date of Birth: _____/_____/_____ Age: _____ Sex: Male / Female

Name: _____
(First) (Middle) (Last)

Address: _____

City: _____ State: _____ Zip: _____ Home Phone ( )_____

Email Address: _____ Cell Phone ( )_____

Marital Status: (circle one) Single Married Divorced Widowed Social Security #_____
(REQUIRED)

PRIMARY INSURANCE-SUBSCRIBER'S SOCIAL SECURITY NUMBER AND DATE OF BIRTH REQUIRED-

Subscriber Name: _____ Relation: _____ Date of Birth: _____
Address: _____ City: _____ State: _____ Zip: _____
Phone #: ( ) _____ Social Security # (REQUIRED): _____
Employer: _____ Work Phone: ( ) _____
Type of Insurance: _____ Policy #_____ Group # _____

SECONDARY INSURANCE- SUBSCRIBER'S SOCIAL SECURITY NUMBER AND DATE OF BIRTH REQUIRED-

Subscriber Name: _____ Relation: _____ Date of Birth: _____
Address: _____ City: _____ State: _____ Zip: _____
Phone #: ( ) _____ Social Security # (REQUIRED): _____
Employer: _____ Work Phone: ( ) _____
Type of Insurance: _____ Policy #_____ Group # _____

COMMERCIAL - MEDICARE - SELF PAY - MVA - PERSONAL INJURY - WORKMAN'S COMPENSATION

I request that payment of authorized benefits be made either to me or on my behalf to Foot & Ankle Specialists of Bucks County for any services furnished me by this office. I authorize any holder of medical information about me to the Health Care Financing Administration and its agents any information to determine these benefits or the benefits payable for related services. I hereby authorize my insurances to furnish to the above named office any information regarding my insurance claims under Title XVIII of the Social Security Act. I request that payment of Authorized Medigap benefits be made wither to me or on my behalf to the Foot & Ankle Specialists of Bucks County for any services furnished me by that physician/supplier. I authorized any holder of medical information about me to my Medigap Carrier any information needed to determine these benefits payable for related services.

I hereby authorize release of information necessary to file a claim with my insurance company and assign benefits otherwise payable to me, to the office indicated on the claim. I understand I am financially responsible for any services rendered by The Foot & Ankle Specialists of Bucks County. I authorize release of my medical information from this office to other health care providers. A copy of this signature is as valid as the original. I/We understand that I/We are responsible for reasonable attorney fees, court costs and cost of collections on any account that becomes delinquent by 45 days. There is a $35.00 (thirty five dollars) charge cash or credit card (ONLY) payment due immediately on ALL returned checks.

We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from getting much needed treatment. If an appointment is not cancelled at least 24 hours in advance you will be charged a thirty five dollar ($35.00) for the first offense and then fifty dollar ($50.00) fee for any subsequent missed appointment. This fee will not be covered by your insurance company. Any account sent to collections for non-payment will be subject to a 25% penalty.

X_____NAME OF INSURED:_____
(signature) (please print name of insured)

Patient Name:_____ Date of Birth:_____

Family Doctor: _____ Todays Date: _____

Height: _____ (FEET) _____ (INCHES) Weight: _____ (LBS.) Shoe Size: _____ Shoe Width:_____

Pharmacy Name, Phone Number, Street it is on & Zip Code: _____
(Required to Send Prescriptions)

1. Describe your foot or ankle problem (detailed):_____

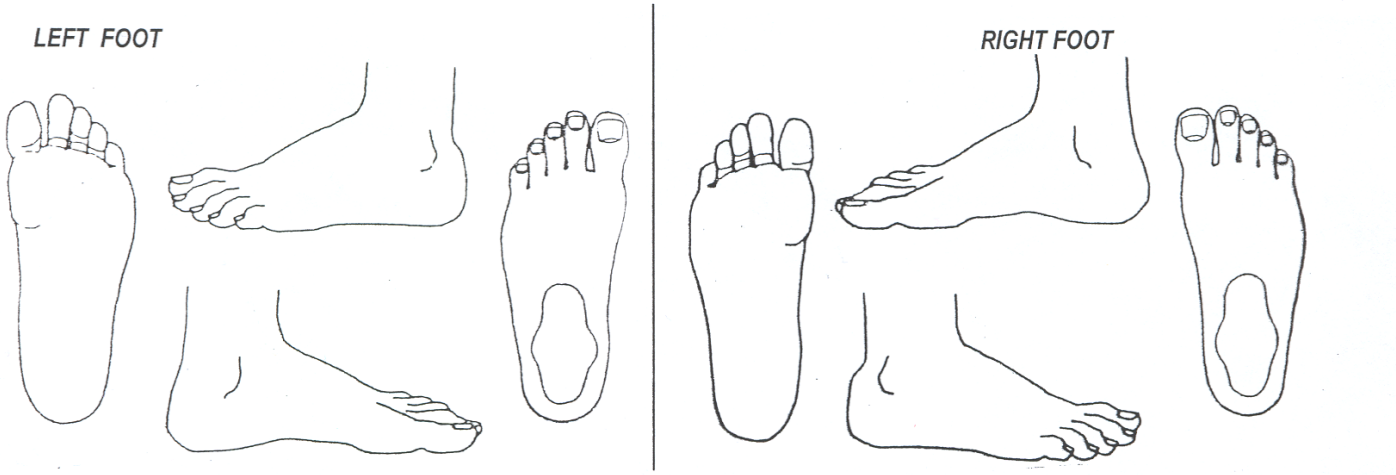
_____

2. How many days, weeks, months, or years have you had this problem (specific)_____
3. Have you been previously treated for this problem? If so, by whom and when? _____

_____

4. Is this a Workman's Compensation Claim/Personal Injury or Motor Vehicle related injury? Yes or No (Circle one)

Please Mark The Area Of Concern Below:



5. How were you referred to our practice? ☐ Yellow Pages ☐ Insurance Directory ☐ Sign

☐ Patient / Friend ☐ Employee ☐ Doctor ☐ I was a previous patient ☐ Google/Internet

Whom may we thank?_____

6. Have you had previous treatment for other foot & ankle problems? If so, when and reason?_____

_____

7. Are you currently being treated for any illness? If so please list?_____
8. Past Surgery (list all surgeries you've had performed, including non-foot procedures):_____

_____

9. Please list all medications that you are currently taking:_____

_____

10. ALLERGIES (Please list all & reaction type)_____

_____

11. Do you participate in sports? If so please list type._____

12. Do you smoke cigarettes? ☐ Yes, Number of Years_____Packs per Day_____ ☐ No

13. Consume Alcohol? ☐ None ☐ Socially ☐ Frequently ☐ Past Alcohol Abuse

Medical History (Check the appropriate column)

	YES	NO		YES	NO
Anemia	_____	_____	Hepatitis (Type _____)	_____	_____
Arthritis	_____	_____	High Blood Pressure	_____	_____
Bleeding problems	_____	_____	HIV-AIDS	_____	_____
Blood Clots (DVT)	_____	_____	Joint Replacement Surgery	_____	_____
Blood Transfusion	_____	_____	Kidney Problems	_____	_____
Circulation problems	_____	_____	Liver Problems	_____	_____
Cholesterol	_____	_____	Pacemaker	_____	_____
Diabetes (Type _____)	_____	_____	Phlebitis	_____	_____
Drug Dependency	_____	_____	Pulmonary Embolism	_____	_____
Epilepsy	_____	_____	Rheumatic Fever	_____	_____
GI Ulcers	_____	_____	Sickle Cell Anemia	_____	_____
Gout	_____	_____	Sickle Cell Trait	_____	_____
Heart Murmur	_____	_____	Stroke	_____	_____
Heart Trouble	_____	_____	OTHER:	_____	

Family History (Check the appropriate column)

	(Y)	(N)	List Family Member		(Y)	(N)	List Family Member
Arthritis	___	___	_____	Diabetes	___	___	_____
Blood Clots (DVT)	___	___	_____	Heart Disease	___	___	_____
Cancer	___	___	_____	Other: _____			_____
Bad Circulation	___	___	_____				

Consent

I hereby give permission to Dr. Mitchell Kahn / Dr. Steven M. Remus / Dr. Erigena Baze-Dhami to examine and administer treatment as may be deemed necessary in the diagnosis and/or treatment of my foot and/or ankle problem(s).

X_____ _____

Signature Date

Relationship to Patient (if patient is a minor)_____