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.

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):_____

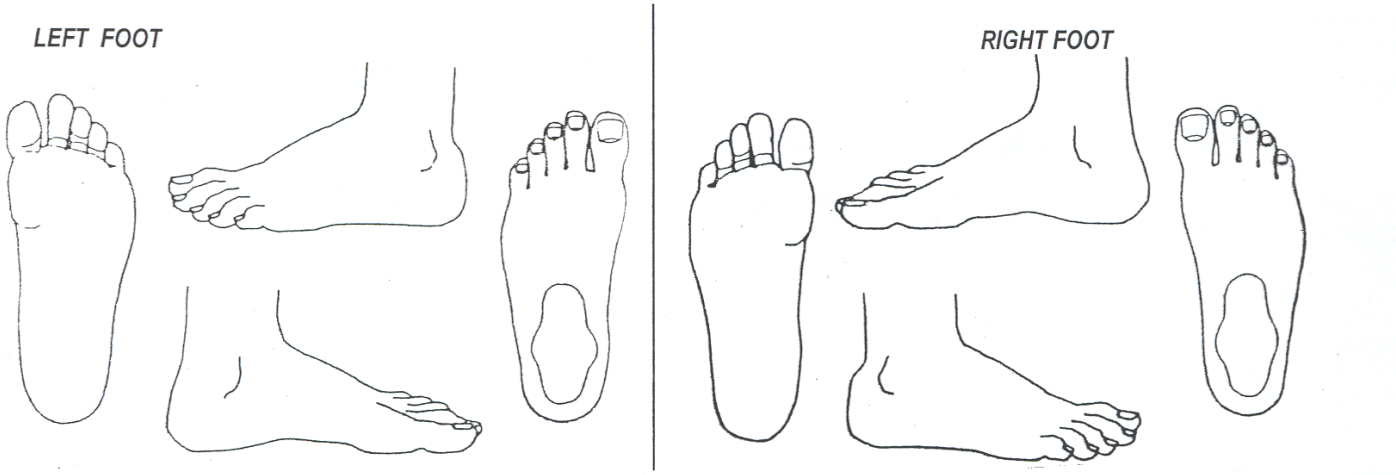
_____

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)_____