FAMILY FOOT CARE CENTER

JEFFREY MARTONE, D.P.M.

LAST NAME____________________ FIRST NAME____________________ MI_____

STREET ADDRESS____

CITY____________________________ STATE__________ ZIP__________

PRIMARY NUMBER (____)__________ 2ND NUMBER (____)__________ EXT_______

BIRTHDATE____________ AGE_____ MARITAL STATUS_______________ SEX: M/F

SOCIAL SECURITY #________________ OCCUPATION____________________

EMPLOYER NAME AND ADDRESS____________________________________

____

PRIMARY CARE DOCTOR **NAME/PHONE**__________________________________

____

PHARMACY **NAME/ADDRESS/PHONE**__________________________________

WHOM MAY WE THANK FOR REFERRING YOU TO OUR OFFICE?__________________

PLEASE LIST YOUR MEDICATIONS_____________________________________

____

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PLEASE LIST ANY ALLERGIES_______________________________________

____

PLEASE CIRCLE OR LIST ALL OF YOUR MEDICAL CONDITIONS BELOW:

ASTHMA ANEMIA DIABETES FOOT SURGERY KIDNEY DISEASE GLAUCOMA

GOUT HEPATITIS CANCER TUBERCULOSIS HIGH BLOOD PRESSURE

ULCERS POOR CIRCULATION HEART DISEASE LIVER DISEASE

OTHER:____

PLEASE COMPLETE OTHER SIDE

PRIMARY INSURANCE

NAME OF COMPANY____________________

ID NUMBER____________________

GROUP NUMBER____________________

NAME OF INSURED____________________

INSURED SOC. SEC.#____________________

INSURED DATE OF BIRTH____________________

SECONDARY INSURANCE

NAME OF COMPANY____________________

ID NUMBER____________________

GROUP NUMBER____________________

NAME OF INSURED____________________

INSURED SOC. SEC.#____________________

INSURED DATE OF BIRTH____________________

IN CASE OF EMERGENCY, WHOM SHOULD WE CONTACT?

NAME____________________ RELATIONSHIP____________________ PHONE(____)____________________

I HEREBY GIVE PERMISSION TO THE DOCTOR TO RELEASE ANY INFORMATION TO MY INSURANCE COMPANY ACQUIRED DURING THE COURSE OF MY EXAMINATION AND TREATMENT. I AUTHORIZE AND DIRECT MY INSURANCE BENEFITS TO BE PAID DIRECTLY TO THE DOCTOR. **I ACCEPT FINANCIAL RESPONSIBILITY FOR ANY NON-COVERED SERVICES, AND ALL UNPAID BALANCES.** I HEREBY GIVE THE DOCTOR PERMISSION TO ADMINISTER TREATMENT AND PERFORM ANY SUCH GENERAL PROCEDURES AS HE/SHE MAY DEEM NECESSARY FOR THE DIAGNOSIS AND TREATMENT OF MY CONDITION. THIS INCLUDES BUT IS NOT LIMITED TO ADMINISTRATION OF LOCAL ANESTHESIA, MINOR SURGICAL PROCEDURES, AND X-RAYS.

PATIENT SIGNATURE____________________ DATE____________________

I ACKNOWLEDGE THAT I WAS GIVEN AN OPPORTUNITY TO READ A COPY OF THE NOTICE OF PRIVACY PRACTICES AND THAT I HAVE READ (OR HAD THE OPPORTUNITY TO READ IF I SO CHOSE) AND UNDERSTAND THE NOTICE.

PATIENT SIGNATURE____________________ DATE____________________