Marc S. Glovinsky, DPM, FACFAS
Celia L. Storey, DPM
Denise L. Johnson, DPM

Please Complete Both Sides of Form
Medicine and Surgery of the Foot

Welcome To Our Office

Personal Information

Today's Date ______/______/_________

Last First Middle

Patient's Name ____ SS# ____________________________

Home Address ____ Date of Birth _________/_________/___________

City ________________________________ State ___________ Zip__________________

E-Mail ____ Male or Female

Home Phone ________________ Work Phone __________________ Cell Phone _________________

Occupation ______________________________ Employer ___________________________________

Emergency Contact Name ____

Emergency Contact Phone ____

Insurance Information (Provide us with your insurance card) Insured DOB ___________________

Name of Insured ____________________Relation to Insured__________Insured SS#________________

Primary Insurance Co. ___________________________ Secondary Insurance ______________________

ID/Group Number ___________________________ ID/Group Number _____________________________

Authorization to Release Information and Assignment of Benefit

1. I authorize release of any and all medical information necessary for care & to process this claim.
2. I hereby authorize Marc S. Glovinsky, DPM, LLC to apply for benefits on my behalf for covered services rendered by him, or by his order. I request payment from my insurance company be made directly to Marc S. Glovinsky, DPM, LLC.
3. I certify that the information I have reported with regard to my insurance coverage is correct.
4. I understand that I am personally responsible for payment of services rendered.
5. I permit a copy of this authorization to be used in place of the original.
6. I understand that honest and complete answers to each question are important to the provision of my medical care and I have answered them to the best of my ability.
7. I consent to receive electronic communication/appointment reminders to the phone/email above.
8. Notice of Privacy Practices is posted online at www.footankledoc.com. A copy is available in the office upon request. I have read or had the opportunity to read, and understood the notice.

____ ____________________

Signature Date

Whom may we thank for referring you? *Yellow pages* *Family Doctor* *Sign* *Friend/Relative* *Insurance Manual* *Internet* *Other*:______________________________________

V5.20

Please Complete Back Of Form

Medical Information Primary Care Physician____
Height:_____ ' ______" Weight:____________ Pharmacy/Location ______________________________

Allergies

None Penicillin Sulfa Drugs Codeine Aspirin Tape Latex Iodine/Shellfish

Other Allergies:____

Medications with Dosage / Previous Surgeries

_______________________ _______________________ _______________________
_______________________ _______________________ _______________________
_______________________ _______________________ _______________________

Social History

Do you smoke? No Yes _____ pk/day x ____ years. Quit, but I smoked ____ pk/day x ___ years.

Drink Alcohol? No Yes if yes, how often ______________________________________

Medical History

Anemia	Yes	No	Drug/Alcohol Dependant	Yes	No	HIV/AIDS	Yes	No
Arthritis	Yes	No	Diabetes	Yes	No	Kidney Disease	Yes	No
Asthma	Yes	No	Gout	Yes	No	Mitral Valve Prolapse	Yes	No
Bleeding Disorders	Yes	No	Heart Disease	Yes	No	Seizures	Yes	No
Blood Clots	Yes	No	Heart Attack	Yes	No	Shortness of Breath	Yes	No
Bronchitis	Yes	No	Heart Murmur	Yes	No	Stomach Ulcers	Yes	No
Cancer	Yes	No	Hepatitis	Yes	No	Stroke	Yes	No
Circulation Disorder	Yes	No	High Blood Pressure	Yes	No	Thyroid Disorder	Yes	No
Chest Pain	Yes	No	High Cholesterol	Yes	No	Tuberculosis	Yes	No

If yes to any of the above, please give details.

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____

Other ____

Foot problem? ____

____

Right Foot Left Foot Both Feet

Circle your choices

How long has it been present? : ____day(s) week(s) month(s) year(s)

When does it hurt: ____

Any previous treatment? ____

Include over the counter remedies

Any previous foot surgery of any kind for this problem or other problems? _______________________

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