TATAR PODIATRY GROUP—PATIENT INFORMATION

Please **PRINT** the following information. This information is important for records and your health.

NAME______________________________________ DATE OF BIRTH________________ AGE________

ADDRESS____

____
City State Zip Code

HOME PHONE ( )________________________WORK PHONE ( )______________________________
CELL PHONE ( )________________________ SOCIAL SECURITY NUMBER____________________
MARITAL STATUS_________________________EMAIL ADDRESS________________________________

EMPLOYER/OCCUPATION____
EMPLOYER ADDRESS____

PARENT OR SPOUSE'S NAME____
EMPLOYER/OCCUPATION____

FAMILY PHYSICIAN______________________________ADDRESS_______________________________
PHYSICIAN'S PHONE_____________________________DATE OF LAST VISIT_____________________
PREFERRED PHARMACY__________________________PHARMACY NUMBER____________________

What is your main foot complaint?____
Former Podiatrist____ Last Visit_______________________

INSURANCE INFORMATION:
Who is responsible for this account?____
Relationship to the patient____

Insurance Company_______________________________ Name of insured on card______________________
Agreement Number________________________________Group Number_____________________________

Assignment and Release
I, the undersigned, certify that I(or my dependent) have insurance coverage and assign directly to Tatar Podiatry Group all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party Signature_____________________________Relationship________________ Date___________

Medicare Authorization
I request that payment of authorized Medicare benefits be made either to me or on my behalf to Tatar Podiatry Group for any services furnished me by that physician. I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries, carries and agents any information needed to determine the benefits for this or a related claim. Alas, I permit a copy of this authorization to be used in place of the original, and request payment of the medical insurance benefits either to myself or to the party who accepts assignment. Regulations pertaining to Medicare assignment of benefits apply.

Signature____ Date_________________________________

PATIENT INFORMATION

NAME (please print):____________________________________

Do you have any allergies to medication? If so, please list:

____

Do you currently take any medications? If so, please list:

____

Have you ever been treated for any of the following conditions?

Heart disease	yes	no	High blood pressure	yes	no
Diabetes	yes	no	Asthma	yes	no
Arthritis	yes	no	Gout	yes	no
Stomach ulcers	yes	no	Stomach problems	yes	no
Liver disease	yes	no	Kidney disease	yes	no
Thyroid problems	yes	no	Stroke (CVA)	yes	no
Bleeding disorders	yes	no	Seizure disorders	yes	no
Phlebitis	yes	no	Cancer	yes	no
Physical disabilities	yes	no	Rheumatic fever	yes	no
Cataracts	yes	no	Glaucoma	yes	no

Do you smoke? If yes, how much per day?____

Have you ever had surgery? Why?____

Have you ever been hospitalized? Why?____
Have you ever been treated for hepatitis? yes / no HIV? yes / no Alcoholism? yes / no

In case of emergency, we are to notify________________________________ Phone_____________________
Relationship to patient____

Whom may we thank for referring you to our office?____

CONSENT
I certify that the above information is true and correct to the best of my knowledge. I give my permission to TATAR PODIATRY GROUP to perform the necessary examination and administer treatment of my condition.

DATE___________________________________ SIGNATURE____