BOWIE FOOT&ANKLE
Howard Horowitz, DPM

New Patient Information

Today's Date:

PATIENT INFO:

Name:

Sex:

Date of Birth:

Address:

City

State

Zip

Home Phone:

Work Phone:

Cell Phone:

Email:

Social Security #:

Martial Status:

Employment Status:

Place of Employment:

****If Child, list parent's name:**

Father:

Mother:

RESPONSIBLE PARTY: *(If same as patient, just write "self)*

Name:

Sex:

Home Phone

Address:

Work Phone

Cell Phone:

Date of Birth:

Email:

Relation:

	PRIMARY INSURANCE	SECONDARY INSURANCE
Insurance Company		
Policy Holder		
Id Number		
Group Number		
Policy Holder DOB		
Policy Holder SSN		
Relationship to policy Holder		

FOOT HEALTH: Circle if you are now or have been treated for:

Are your first steps out of bed painful? ☐ YES ☐ NO

Then subsides? ☐ YES ☐ NO

Do you get leg cramps during the day? ☐ YES ☐ NO

At night? ☐ YES ☐ NO

Any pain in calves or buttocks when walking? ☐ YES ☐ NO

YES NO Is it relieved by stopping & standing still? ☐ YES ☐ NO

List of sports/type of dance you are active in:

Your type of job activity/occupation:

Hours per day on feet:

Shoe Size:

Weight (lbs):

Height:

GENRAL HEALTH HISTORY: Circle: if you are now or have you ever been treated for:

☐ Stroke ☐ Vascular Disease ☐ Headache ☐ Sciatica ☐ Keloid/thick scar

☐ Psychiatric Disorder ☐ Ling Disease ☐ Osteoporosis ☐ Heart Attack ☐ Heart Condition

☐ Hepatitis ☐ Rheumatic Fever ☐ Nerve Disorder ☐ Kidney disease ☐ Tuberculosis

☐ Poor Circulation ☐ High Blood Pressure ☐ Diabetes ☐ Liver Disease ☐ Alzheimer's

☐ Hearing/ear disorders ☐ Thyroid Problem ☐ Stomach Ulcer ☐ Arthritis ☐ Phlebitis

☐ Insulin yes/no ☐ Anemia ☐ Epilepsy ☐ Glaucoma ☐ Asthma ☐ Cancer

☐ Lyme's Disease

Do you have joint implants? ☐ YES ☐ NO

If yes where?

Do you have a history of heart valve problems? ☐ YES ☐ NO

Drink alcoholic beverages? ☐ None ☐ rarely ☐ moderately ☐ daily ☐ quit

User recreational drugs? ☐ None ☐ rarely ☐ moderately ☐ daily ☐ quit

Smoker? Former

Never

Current: Packs/day:

Years:

List major surgeries	Date

Other hospitalizations:

Date

Your preferred pharmacy:

Phone:

Address:

Your General Physician:

Phone:

Street/City:

ALLERGIES: Are you allergic to any of the following? Please circle:

☐ Penicillin ☐ Advil ☐ Codeine ☐ Aleve ☐ Demerol ☐ SulfaDrugs ☐ Novocain ☐ Motrin ☐ Aspirin ☐ Adhesive Tape

Please List any others:

MEDICATIONS: Please list any medications you are currently taking:
*if additional space is needed please continue on back

Medication/Dose	Reason for taking	Frequency

How did you hear about our office/who should we thank for referring you to us? ☐ Doctor ☐ Patient ☐ Family/Friend ☐ Phone Book ☐ Online

Name/Source:

Today's Foot Complaint:

Duration:

2nd foot complaint:

Duration:

Dr. Note:

BOWIE FOOT&ANKLE
Howard Horowitz, DPM

INSURANCE AUTHORIZATION AND ASSIGNMENT

Please remember insurance is not a substitute for payment. Some companies pay fixed allowances for certain procedures, and other pay a percentage of the charge. IT IS YOUR RESPONSIBILITY TO PAY ANY DEDUCTIBLE AMOUNT, CO- INSURANCE, COPAY OR ANY OTHER BALANCE NOT PAID FOR BY YOUR INSURANCE. We request that these charges be paid at the conclusion of each visit. If it becomes necessary for this account to be turned over for collection, you will be responsible for all related costs as well as any balance due.

I hereby authorize any holder of medical and/ or other information about me needed to determine benefits for related services to release such information to the Centers of Medicare & Medicaid Services or other insurance companies. I hereby assign all medical and/ or surgical benefits to which I am entitled, including Medicare, private insurance and other health plans to: Howard Horowitz, D.P.M. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand I am financially responsible for all charges whether or not paid by said insurance including NO SHOW or MISSED appointment fees in the amount of $50.00, and appointments not cancelled within 24 hours.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read if I so chose) and understood the Notice.

Name (Print Please) **Date**

Signature

* If you would like a copy of HIPAA please ask the front desk *