MIKEL DANIELS, DPM, FACFAS, FAPWCA, FASPS, WCC
MARC SINGER, DPM
MAZIN SADIK, MD, DPM
FRANCISCO PIZARRO, DPM
WHITLEY WILLIAMS, DPM
ZAHRA DEHGHANI, DPM

WE TREAT FEET PODIATRY

www.wetreatfeet.com PHONE: 410-363-4343 FAX: 410-356-6373

CONFIDENTIAL NEW PATIENT INFORMATION SHEET DATE ____/____/____

NAME: _____ BIRTH DATE: ____/____/____
ALLERGIES: _____ SS#_____
MAILING ADDRESS: Street _____
City/Town: _____ State: _____ Zip Code: _____
PHONE: _____ CELL/BUSINESS: _____/_____
EMAIL: _____
CAREGIVER: _____ MARTIAL STATUS _____
**EMERGENCY CONTACT NAME _____ PHONE NUMBER:_____
DO YOU TAKE:
BLOOD THINNERS HEART MEDS ANTIDEPRESSANTS ANTIBIOTICS BLOOD PRESSURE MEDS

LIST OF MEDICATIONS:
_____

LIST OF OPERATIONS:
_____

MEDICAL FAMILY HISTORY-DOES ANYONE IN YOUR FAMILY HAVE/HAD:
DIABETES HIGH BLOOD PRESSURE HIGH CHOLESTEROL STROKE HEART ATTACK

REFERRED BY OR HOW DID YOU HEAR OF US: _____
WHY DID YOU COME TO THE PODIATRIST?
1. _____
2. _____
RIGHT FOOT LEFT FOOT BOTH FEET
**HOW LONG HAVE YOU HAD THIS PROBLEM: _____

PAYMENTS: Patients are responsible for all fees including missed visits, late cancels and returned checks. Payment is expected at the times services are rendered. Payment exceptions must be arranged before treatment. Referrals if needed are the responsibility of the patient to obtain and that charges incurred from the absence of a referral are the responsibility of the patient.
I authorize Wiener and Daniels, DPM, PA and the providers of such company to provide services, and medications, and submit my insurance form, consider my signature "on file" for payment, pictures, and to release any and all records need for insurance processing and communication with other caregivers, including images. I understand the HIPPAA, office privacy policy and have read and understand the above and agree to be personally responsible for all charges and fees.

Signature of patient or responsible party: _____

Printed name: _____ DATE: / /

PATIENT NAME: DATE OF BIRTH

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PRIMARY INSURANCE NAME	SECONDARY INSURANCE NAME
PRIMARY ID#	SECONDARY ID #
PRIMARY POLICY HOLDER NAME AND SS#	SECONDARY POLICY HOLDER NAME AND SS#
POLICY HOLDER RELATIONSHIP TO PATIENT AND DOB	2ND POLICY HOLDER RELATIONSHIP TO PATIENT AND DOB

PRIMARY CARE DOCTOR NAME:
PRIMARY CARE DOCTOR PHONE NUMBER:
LAST DATE YOU SAW YOUR PRIMARY CARE DOCTOR:
DO YOU SEE AN ENDOCRINOLOGIST? YES OR NO
IF YES WHAT IS YOUR ENDOCRINOLOGIST NAME AND PHONE NUMBER:
LAST DATE YOU SAW YOUR ENDOCRINOLOGIST:

WORKER'S COMP OR AUTO ACCIDENT INFORMATION NEEDED:
**ALL MUST BE COMPLETED FOR CLAIMS TO BE PAID.

CASE NUMBER: _____ DATE OF INJURY: _____

SS# OF PATIENT: _____ NAME OF EMPLOYER:_____

INSURANCE CARRIER: _____

ADDRESS OF INSURANCE: _____

_____

CONTACT PERSON: _____

PHONE NUMBER: _____

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PATIENT COMBINED CONSENT FORM FOR INSURANCE AND OFFICE POLICIES

HIPAA RELEASE OF INFORMATION AUTHORIZATION FORM

I hereby certify that the information I have provided regarding insurance coverage is correct and I authorize the office of Wiener and Daniels, DPM, PA to verify my Insurance coverage and benefits allowed in accordance with my insurance plan's policies. I authorize that payments be made directly to Wiener and Daniels, DPM, PA for all my medical benefits which are payable under the terms of my insurance policy for the services provided. I agree to pay any co-payments, co-insurances, or deductibles as required by my insurance plan for medical care provided to me or my dependent. I understand that I am responsible for knowing the terms and regulations of my insurance plan, and that specialist referrals are my responsibility at all times. I agree to accept full responsibility for payment if my insurance coverage is interrupted or terminated during my care. I agree to pay for medical services provided to myself or my dependent(s) which are not covered by the benefits of my insurance plan. I agree to the above stated responsibility.

I hereby authorize Wiener and Daniels, DPM, PA and its affiliates, its employees and agents, to submit claims to my insurance company, health or welfare fund, Medicare or Medicaid for medical services provided to me or my dependents. Including Information relating to the diagnosis, treatment, claims payment, and health care services provided or to be provided to me and which can identify my name, address, social security number, and Member ID number. I authorize any medical or incidental information that may be necessary for either medical care or for processing application for financial benefit, including outside vendors that may be used on my behalf for surgical procedures, or wound care, etc.; that provide services or durable medical equipment for said surgical services or equipment.

RECEIPT OF NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I certify that I have been informed and given access to a copy of Wiener and Daniels, DPM PA Notice of Privacy Practices.

CONSENT FOR RELEASE OF MEDICAL INFORMATION

I authorize the release of information including the diagnosis, records, examination rendered to me, appointment times, and claims information. This information may be released to:

Spouse:_____

Child(ren): _____

Other: (relationship)_____

NAME OF PATIENT: _____ DATE OF BIRTH _____

SIGNATURE OF PATIENT: _____ DATE: ___/___/____