

PATIENT INFORMATION (Please Print)

Date _____
Last Name _____
First Name _____ MI _____
Address _____
City _____
State _____ Zip _____
Home Phone(____) _____
Cell Phone(____) _____
Work Phone(____) _____
E-mail _____
Marital Status S M D W
Date of Birth _____
Sex M F
S.S. _____

Chief Complaint _____

PRIMARY PHYSICIAN

Phone # _____
Address _____
City, St, Zip _____

PATIENT EMPLOYMENT

Employer _____
Occupation _____
Address _____
City _____
State _____ Zip _____
Phone (____) _____

INSURANCE

Insurance Co. _____
Address _____
City _____
State _____ Zip _____
Group # _____ I.D.# _____

SECONDARY INSURANCE

Insurance Co. _____
Address _____
City _____
State _____ Zip _____
Group # _____ I.D.# _____

RESPONSIBLE PARTY

(Person to be billed or insurance carrier)

Last Name _____
First Name _____ MI _____
Address _____
City _____
State _____ Zip _____
Phone (____) _____

Date of Birth _____

S.S. _____

RESPONSIBLE PARTY EMPLOYMENT

Employer _____
Occupation _____
Address _____
City _____ State _____ ZIP _____
Phone (____) _____

MEDICATIONS/OTC/VITAMINS:

PAST SURGICAL HISTORY (type of surgery and year surgery was performed)

ALLERGIES

SOCIAL HISTORY

Do you smoke _____ Yes _____ No

How much _____ How long _____

Do you drink alcohol _____ Yes _____ No

How much _____ How long _____

What type of job do you have

Where did you hear about our services

from (Please circle one) Yellow pages

Internet Dr. Referral Friend TV

Newspaper Health fair Radio

FAMILY HISTORY:

Alcoholism Mother Father

Diabetes Mother Father

Anesthesia Prob. Mother Father

Heart Problems Mother Father

Arthritis Mother Father

Neurological Disorder Mother Father

Cancer Mother Father

Respiratory Mother Father

Cystic Fibrosis Mother Father

Seizures Mother Father

PAST MEDICAL HISTORY

Cardiovascular: (check all that apply)

- Congestive heart failure Murmur
- Deep Vein Thrombosis Rheumatic
- General Cardiovascular Problems Stroke
- High or Low Blood Pressure

Childhood Illnesses:

- Asthma Ear Infection Measles
- Chickenpox Influenza Mumps

Dermatologic:

- Candidiasis (yeast infection) Keratosis
- Skin Cancer
- Cellulitis Psoriasis Warts
- STD Fungal Infections
- Itchy Dry Skin Raynaud's phenomenon

Endocrine:

- Diabetes Hypoglycemia Obesity
- Hypothyroidism Menopause

Congenital/Genetic Background:

- Autism Hemophilia
- Cystic Fibrosis Muscular dystrophy

Gastric Intestines:

- Cancer Diverticulitis GI bleed
- Colitis GERD Liver conditions
- Crohn's Gastritis
- Stomach or bowel problems

GU:

- Bladder dysfunction Kidney problems
- Dialysis

Heent Hx:

- Allergic Rhinitis Ear conditions
- Nasal conditions
- Dentures/Partials Eye conditions
- Throat conditions

Hematological:

- Anemia Hemophilia Lymphoma
- Leukemia Bleeding abnormalities

Musculoskeletal:

- Amputation Ganglion Osteomyelitis
- Arthritis Gout Osteoporosis
- Fracture history Neoplasm

Neurological History:

- Alzheimer's Multiple Sclerosis
- Seizure Disorder
- Aneurysm Neurofibromatosis Sciatica
- Migraines Neuropathy

Psychiatric:

- Alcoholism Depression
- Dementia Drug abuse

Respiratory:

- Asthma Emphysema Pneumonia
- COPD Lung Cancer Tuberculosis

REVIEW OF SYSTEMS

Allergic/Immunologic Cardiovascular

- seasonal allergies sensitivity to dust
- arm pain high blood pressure
- coughing chest pain chest pressure
- cold hands cold feet
- calf cramping

Constitutional Symptoms

- sleep problems fever

Ear, Nose, Mouth, Throat

- dizziness headache hearing loss
- sore throat
- faintness blisters in mouth sinus problem

Endocrine

- dry hair cold intolerance

Eyes

- weight changes dry eyes itchy eyes
- excess tearing glaucoma

Gastrointestinal

- macular degeneration
- abdominal pain heartburn

Genitourinary

- blood in stool currently pregnant
- painful urination
- on dialysis

Hematologic/Lymphatic

- ankle/foot edema calf pain

Integumentary/Skin

- bruise easily bleeding problems
- athlete's foot discoloration
- cyst leg swelling
- dry, scaly skin lower leg ulcers

Musculoskeletal

- back pain joint swelling

Neurological

- heel pain muscle pain dizziness
- migraines
- hip pain neck pain confusion
- seizures
- joint pain stiffness forgetfulness
- tingling
- headache tremors

Respiratory

- difficulty breathing
- shortness of breath
- chest tightness
- snoring

PLEASE READ AND SIGN

The above information is correct to the best of my knowledge and I consent to such diagnostic procedures and medical care as deemed necessary by the doctor for my treatment. I also consent to have photographs taken which will be used solely for medical education.

I understand that I am responsible for any charges incurred during any visit or treatment by the doctors and staff of Dr. Malinsky's office. My insurance company may not cover my charges for the following reasons: I did not bring a referral for this care, the referral did not arrive in time for the visit, my insurance company may not cover the service, my insurance may not be in effect, the charges maybe applied to my deductible/co pay. The doctors and staff of Dr. Malinsky's office will file my insurance when appropriate, but I will be ultimately responsible for all charges. A fee schedule can be obtained up on request.

I understand that payment is due at the time of service with no insurance or for non-covered services and due within 90 days when filed with my insurance company. I understand that late fees and/or interest may be applied to my bill if not paid within the 90 day period.

Patient/Parent/Guardian

Date

AUTHORIZATION FOR TREATMENT & RELEASE OF INFORMATION FOR PODIATRY SERVICE

The resident, legal guardian or health care surrogate, if any, hereby authorizes Dr. Malinsky, DPM and associates and staff to examine and treat, if necessary: (i.e. Fungal nails, Ingrown nails, pressure ulcer care, diabetic foot care, dispense braces and diabetic shoes).

_____ (name of patient)

This consent may be withdrawn at any time. Withdrawal of consent must be in writing to Dr. Malinsky, DPM and staff. The resident, legal guardian or health care surrogate authorized Dr. Malinsky, DPM and staff to disclose appropriate clinical information to facility staff for purpose of treatment. Clinical information can be released to family members listed here for purposes of treatment.

- 1. _____
- 2. _____
- 3. _____

The resident, legal guardian or health care surrogate, if any, has READ and has had fully explained to him/her, and fully understands the above Authorization for Treatment. No assurance or guarantee has been made to the resident, legal guardian, or health care surrogate, if any, concerning the results, which may be obtained. A fee schedule may be obtained upon request.

ASSIGNMENT OF BENEFITS

In order to submit a claim for services under your policy, we must have your authorization to release medical information to your carrier. As a Medicare participation provider, Dr. Malinsky, DPM and staff will accept assignment. Even though services may be approved by your insurance, there is no guaranty of payments. According to Medicare Guidelines, the provider will always accept the amount that Medicare approves with excess charges to be billed to secondary carriers, including Medigap if applicable.

MEDICARE AUTHORIZATION

I request that payment of authorized benefits may be made to Dr. Malinsky, DPM. I authorize any holder of Medical Information to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I hereby

authorize Medicare to furnish to Dr. Malinsky, DPM any information regarding Medicare claims under the Title XVIII of the Social Security Act.

PRIMARY & SUPPLEMENTAL INSURANCE

I hereby authorize the release of any information necessary to file a claim with the insurance company and assign benefits to Dr. Malinsky, DPM and staff. This includes any coverage under Medigap. For patients with Medicare: Medicare makes payments only after a yearly deductible has been satisfied. For patients with both Medicare and Medicaid: Medicaid does not pay the Medicare annual deductible amount, this will be billed to the patient or responsible party. For patients with Medicaid: Medicaid does not pay for this service. For patients with Preferred Senior Care: Preferred Senior Care is not expected to pay for this service. Patient or responsible party agrees to pay all charges not covered by Medicare, Medicaid, Medigap, VA, or other insurance. Medicaid does not cover podiatry services after age 18, therefore all Medicaid will be charged to the patient or responsible party. Failure to pay charges is agreed to imply discontinuation of this podiatry service.

Signature: _____

Date: _____