

IRA E. BENNETT, D.P.M., P.A.

PODIATRIC PHYSICIAN AND SURGEON
FELLOW, AMERICAN COLLEGE OF FOOT SURGEONS

WELCOME

This information is confidential

**PLEASE COMPLETE BOTH SIDES OF FORM.
PLEASE PRINT LEGIBLY.**

NAME: _____
Last First Initial

LOCAL MAILING ADDRESS:

Apt. / Lot # Street

City State Zip

TELEPHONE: _____
PERMANENT
ADDRESS: _____
(If different than above)

Telephone: _____

Date of Birth: _____

Social Security # _____

Sex: Male Female
Parents
(if patient a minor): _____

Occupation: _____

Employer: _____

Address: _____

Business Phone: _____

Please have your insurance card(s) available so we may make a photocopy.

Whom may we thank for referring you to our office?

- Doctor _____
- Patient _____
- Family Member _____
- Word of Mouth Phone book / Yellow Pages
- Saw sign / building Newspaper
- Website Lecture
- Health Fair PPC Handbook
- Employee Other: _____

IS YOUR TREATMENT TODAY DUE TO A WORK RELATED INJURY? Yes No

Do you have written authorization to be treated from your employer and workman's compensation carrier?
 Yes No

Marital Status: Single Married _____
 Widowed Divorced Separated
(Spouse's Name)

Drivers License #: _____

State Issued: _____

Spouses Occupation: _____

Employer: _____

Address: _____

Business Phone: _____

Person to contact locally in case of emergency _____
Name Phone #

I hereby authorize the release of any medical information necessary for processing insurance claims and payment of medical benefits to myself or the party who accepts assignment. This authorization will remain valid until revoked by me in writing. I understand that I am legally responsible for all charges whether or not reimbursed by my insurance company.

To control your cost of billings, we request that our charges be paid at the conclusion of each visit.

Signature: _____

MEDICARE SIGNATURE ON FILE

I request that payment of authorized Medicare benefits be made either to me or on my behalf to **IRA E. BENNETT D.P.M., P.A.** for any services furnished me by the listed provider/supplier. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable to related services.

I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in Item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the provider or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

PATIENT'S NAME (Please Print) Date

PATIENT'S SIGNATURE Medicare Number

IRA E. BENNETT, D.P.M., P.A.
Trinity Professional Center
1810 Wellness Lane
New Port Richey, FL 34655

MEDICAL HISTORY

Patient Name: _____ Age: _____ Date: _____

Primary Care Physician: _____ Date Last Seen: _____

What is your foot problem? _____

When did this problem start? _____

Has your foot problem been treated before? No Yes If yes, what treatment? _____

Do you have any of the following medical problems:

- | | | | |
|--|---|---|------------------------------------|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Stroke | <input type="checkbox"/> Gout |
| <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Thyroid Problems | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Raynaud's Disease | <input type="checkbox"/> Low Back Pain | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Phlebitis | <input type="checkbox"/> Kidney Problems | <input type="checkbox"/> Prolonged Bleeding | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Circulation Problems | <input type="checkbox"/> Liver Problems | <input type="checkbox"/> Cirrhosis |
| <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Numbness in Feet or Legs | <input type="checkbox"/> Lung Disease | <input type="checkbox"/> HIV |

Other: _____

ALLERGIES:

- | | | | | |
|------------------------------------|----------------------------------|-------------------------------------|--------------------------------------|--------------------------------|
| <input type="checkbox"/> Novocaine | <input type="checkbox"/> Iodine | <input type="checkbox"/> Penicillin | <input type="checkbox"/> Aspirin | <input type="checkbox"/> Sulfa |
| <input type="checkbox"/> Cortisone | <input type="checkbox"/> Codeine | <input type="checkbox"/> Adhesive | <input type="checkbox"/> Other _____ | <input type="checkbox"/> None |

List any medications that you take: _____

List any surgeries that you have had: _____

Type of anesthetic that you have had: General Local Spinal Other: _____

List any illnesses that you have been hospitalized for besides surgeries: _____

Do you smoke? No Yes If yes, how much do you smoke? _____

Do you drink alcohol? No Yes If yes, how much do you drink? _____

Does any blood relative have any of the following: Diabetes Gout Cancer Heart Disease Other: _____

If yes to any of the above, what is the persons relationship to you? _____