ADVANCED CARE PODIATRY

AISHA CHAUDHRY, DPM   AMMAR SAYMEH, DPM

FOOT + ANKLE SPECIALISTS

www.advancedcarepodiatry.com

Patient Information Form

First/Last Name ____ **Date** ______________________

DOB ______________________ **SSN** ________________________

Address ____ **Apt/Ste** ______________

City __________________________ **State** ________________ **Zip Code** _______________

Phone Number ________________________ **E-mail** ____

What is your occupation? ____

How did you hear about us? ____

Emergency Contact Name ___________________________________ **Phone Number** ________________________

Primary Doctor Name ____

Primary Doctor Phone # ____________________________ **Fax** ___________________________

Primary Insurance ____ **Policy ID #** __________________________

Secondary Insurance ____ Policy ID # __________________________

What is the main reason for your visit? ____

____

____

Have you ever been to a Podiatry doctor before? YES / NO

If yes, please list Doctors name ____

Pharmacy Name ____ **Pharmacy Phone #** _________________________

Pharmacy Address ____

List of Current medications ____

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Please indicate which foot problems you have or have had in the past:

Ankle Pain	YES	NO
Athletes Foot	YES	NO
Bunion	YES	NO
Corns & Calluses	YES	NO
Cramps or numbness	YES	NO
Flat Feet	YES	NO
Heel Pain	YES	NO
Ingrown Toe Nails	YES	NO
Plantar Warts	YES	NO
Swelling in Ankles and/or Feet	YES	NO
Tired Feet	YES	NO

Please list any drug allergies you may have ____

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____

Is there a family history of diabetes? YES / NO

Please list any current, or past medical history that you may have ______________________________

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Insurance Assignment and Release

I certify that I have insurance coverage with ______________________________________ (Name of Insurance Co.) and assign directly to Dr. Aisha Chaudhry D.P.M / Dr. Ammar Saymeh D.P.M all insurance information. If any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges not paid by insurance. I authorize the use of my signature on all insurance submissions. The above-named doctors may use my health information and may disclose such information to the above-named insurance companies and their agents for the purpose to obtain payment for services and determining insurance benefits or the benefits payable for the related services. This consent will end when my current treatment plain is completed or/and year from the date signed below.

Print Patient First/Last Name ____

Signature of Patient, Parent, or Guardian ____

Date Signed ____

Medicare/Medigap Authorization

I request that payment authorized Medicare Benefits and, if applicable, Medigap benefits by made either to me or on my behalf to Advanced Care Podiatry for any servers furnished to me by that provider. To the extent permitted by law, I authorize any holder of medical or other information about me to release to the Center for Medicare and Medical Services, my Medigap insurer, and their agents any information needed to determine these benefits or benefits related to services.

Print Patient First/Last Name ____

Signature of Patient, Parent, or Guardian ____

Date Signed ____

Treatment Consent

I hereby consent and give my permissions to the Doctor and Doctor's Assistant to administer and perform such procedures upon me as the Doctor deems necessary.

Signature of Patient, Guardian, or Personal Representative ____

Date Signed ____