Atlantic Podiatry Center LLC
9811 Mallard Drive, Suite 207 Laurel MD 20708
301-604-9793 Fax: 1-888-272-4284

Dr. Rahul Gor DPM
Dr. Bruce Wenzel DPM
www.atlanticpodiatrycenter.net

## Patient Information

Patient Name:

Last name | First name | M.I.

Desired name: Date of Birth: / / Age:

Social Security Number: - -

Responsible Party:

Mailing address:

Street/P.O. Box | City

State | Zip code

**Email Address** (if we can we email you newsletters and appointment reminders): _____

Home Phone: Cell Phone: **Best Contact #:**

Emergency Contact Person: Phone #:

Gender: **Male☐ Female☐** Marital Status: **Single☐ Married☐ Widowed☐ Separated☐ Divorced☐**

Who do you authorize us to release/discuss your medical information to? **Name:**

APPOINTMENT REMINDERS PREFERENCE (PLEASE CIRCLE): TEXT TELEPHONE

How did you hear about us? **WEB☐ PCP (name: ) FRIEND (name: ) INSURANCE☐**

****PLEASE TELL US WHO REFERRED YOU TO OUR PRACTICE SO WE CAN THANK THEM.****

Employer: Position: Phone:

PREFERRED PHARMACY: Phone:

### Insurance Information

Name of Insured (if not patient);

Relationship to Patient: Employer:

Date of Birth: Occupation:

Social Security Number: Work Phone:

Primary Care Physician (Name/Group):_____

Telphone: _____ Fax (if known):_____

Date last seen by the doctor:_____

### **Insurance & Payment Policy**

It can be very difficult for the average person to understand their insurance plan. Also, many insurance plans are changing. Unfortunately, there are hundreds of different insurance plans and almost all of them have their own rules. There is little consistency from company to company or even among different plans offered by the same company. The need for referrals, deductibles, copays, prior authorization, in network, out of network differs from insurance plan to insurance plan. It is in your best interest to find out your coverage before you arrive at the office for your appointment. No one likes to be surprised by their bill after being seen.

Our office accepts most assignments. Medicare only covers routine foot care for a limited set of conditions and for a limited number of visits. If you don't qualify, you will be responsible for payment.

**Patients are financially responsible for all charges to their account**

**Patients are responsible for insurance referrals**

Copays cannot be waived by law and are due at the time of service.

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## Authorization for treatment, assignment, and Release:

I hereby give the Atlantic Podiatry Center LLC (APC)/Dr. Gor and its staff members permission to treat my feet and/or ankle disorders. I, the undersigned, have insurance coverage with and assign directly to APC/Dr. Gor all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions. I may receive a copy of Notice of Privacy Practices and I have read (or had the opportunity to read) and understand the notice posted in the office.

**Signature of insured/guardian:**

**X** **Date: / /**

## Medicare Authorization:

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Atlantic Podiatry Center LLC/Dr. Gor for any services furnished to me by that physician. 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 for 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 physician 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 non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

**Signature of Insured, Guardian, or Beneficiary:**

**X** **Date: / /**

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## Chief Concern/Present Illness:

What is your present foot problem?

If due to injury, give date and details:

How long have you been bothered by the above?

What have you done for your foot problem? Padding ☐ NSAID's ☐ Altered shoe wear ☐ X-rays ☐
Soaks ☐ Altered Activity ☐ Physical Therapy ☐ Injections ☐ Shoe Inserts ☐ Surgery ☐
Topical Medications ☐

Have you had previous foot care/surgery? If so, by whom?

Is there any other general or foot health information that we should know about?

## Medical History:

Are you now or have you ever been under a physician's care during the past two years? YES ☐ No ☐

Date of last complete physical exam: / /

## Are you allergic to any medications? *** (Circle all that apply)***

| | | | | |
|---|---|---|---|---|
| **No Known Drug Allergies** | Adhesive Tape | Amoxicillin | Aspirin | Augmentin |
| Betadine | Codeine | Demerol | Erythromycin | Ibuprofen |
| Iodine | Keflex | Latex | Morphine | NSAIDs |
| Penicillin | Sulfa Drugs | Tylenol | Novocaine | Antihistamines |
| Other (list to the right): | | | | |

## Medications: *Are you presently taking any medications?* Yes ☐ No ☐

List medications below:

| | | | | |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |

## Past Medical History: (Circle if you now have or were ever treated for)

| | | | |
|---|---|---|---|
| AIDS/ARC | Circulation Disorders | High Blood Pressure | Rheumatic Fever |
| Allergies | Diabetes (insulin **or** non-insulin dependent) | Kidney Disease | Stomach Ulcer |
| Anemia | Epilepsy | Leg Cramps | Stroke |
| Anesthesia Problems | Glaucoma | Liver Trouble | Tuberculosis |
| Arthritis | Gout | Mental Health Conditions | Ulcers |
| Asthma | Heart Disease-Type ( ) | Mitral Valve Prolapse | Venereal Disease |
| Bleeding Tendency | Heart Murmur | Polio | |
| Cancer – Type ( ) | Hepatitis-Type ( ) | Previous Foot Condition | |

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## Have you ever had surgery? ☐ YES ☐ NO

| List type of Surgery below | Year | | Year |
|---|---|---|---|
| 1. | | 5. | |
| 2. | | 6. | |
| 3. | | 7. | |
| 4. | | 8. | |

## Family History: (Circle if any blood relatives have had)

| | | | |
|---|---|---|---|
| Arthritis | Cancer | Diabetes | Heart Disease |
| High Blood Pressure | Kidney Disease | Overweight | Other: (list below) |
| | | | |

Foot problems similar to yours? Mother ☐ Father ☐ Siblings ☐

## Social History:

| | | | | |
|---|---|---|---|---|
| Use of Alcohol: | Never ☐ | Rarely ☐ | Moderate ☐ | Daily ☐ |
| Use of Tobacco: | Never ☐ | Previously but **quit** (date: ) | | Current packs/day ☐ |
| Use of Drugs: | Never ☐ | Type/Frequency ( ) | | |

## Review of Systems: (Please indicate current health status below by circling **existing** conditions)

| **Constitutional Symptoms** | **Gastrointestinal** | **Integumentary (skin)** | **Psychiatric** |
|---|---|---|---|
| Good general Health lately | Loss of Appetite | Rash or itching | Blurred or double vision |
| Recent weight change | Nausea or vomiting | Change in skin color | Memory loss or confusion |
| Fever | Frequent diarrhea | Change in hair or nails | Depression |
| Fatigue | **Genitourinary** | Varicose veins | Insomnia |
| **Eyes** | Kidney Disease | Dry skin | **Endocrine** |
| Eye disease or injury | Dialysis | **Neurological** | Diabetes |
| Wear glasses/contact lenses | Kidney Stones | Frequent or recurring headaches | Glandular or hormone problem |
| **Cardiovascular** | **Musculoskeletal** | Light headed or dizzy | Excessive thirst or urination |
| Chest pain or angina pectoris | Joint pain | Convulsions or seizures | Heat or cold intolerance |
| Shortness of breath | Joint Stiffness or swelling | Numbness or tingling sensations | **Hematologic/Lymphatic** |
| Swelling of feet, ankles or hands | Weakness in muscles or joints | Tremors | Slow to heal after cuts |
| **Respiratory** | Muscle pain or cramps | Paralysis | Bleeding or bruising tendency |
| Chronic or Frequent coughs | Back pain | Head injury | Anemia |
| Spitting up blood | Cold Extremities | Stroke | Phlebitis |
| Shortness of breath | Difficulty in walking | | Past transfusion |
| Wheezing | Neuromuscular disease | | |

**Shoe Size: ( )**

Height:_____ Weight:_____ Last Blood Pressure if known: ____/____

**Thank you for your cooperation!**