Ankle & Foot Centers of Pittsburgh LLC *Date* _____

PATIENT NAME_____ **BIRTHDATE** _____ **AGE** _____ **SEX M / F**

ADDRESS _____**CITY**_____ **ZIP CODE** _____

RESIDENCE PHONE _____**CELL/WORK**_____**E-MAIL**_____

(IF MINOR) FATHER'S NAME _____ **MOTHER'S NAME** _____

PATIENT'S SOCIAL SECURITY NO. _____ **MARITAL STATUS** _____ **RACE** _____

PATIENT OCCUPATION _____ **EMPLOYER** _____

INSURED NAME _____ **INSURED BIRTHDATE** _____/_____/_____

FAMILY PHYSICIAN _____ **PHONE #** _____

PHARMACY _____ **LOCATION** _____#_____

HEIGHT _____ **WEIGHT** _____ (YES, FILL THIS IN) **SHOE SIZE** _____

REASON FOR VISIT TODAY _____

MEDICATION ALLERGIES _____

FOOD ALLERGIES _____ **LATEX ALLERGY Y / N**

PLEASE LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING INCLUDING NON-RX AND HERBAL SUPPLEMENTS

NAME	DOSAGE	NAME	DOSAGE

HAVE YOU EVER HAD OR CURRENTLY HAVE ANY OF THE FOLLOWING? (PLEASE CHECK):

__ ABNORMAL BLEEDING	___ACID REFLUX	___ANEMIA	___ARTHRITIS
___ASTHMA/EMPHYSEMA	___BACK PROBLEMS	___BLOOD CLOTS	___CANCER
___ CIRCULATION PROBLEMS	___ CHOLESTEROL	___DIABETES	___ DISABLED
___EPILEPSY	___FIBROMYALGIA	___FRACTURES	___GOUT
___ HEART ATTACK	___HEART DISEASE	___HEPATITIS	___HIV/AIDS
___HYPERTENSION	___ KIDNEY DISEASE	___LIVER DISEASE	___NEUROPATHY
___OPEN SORES	___ PREGNANCY	___PHELBITIS	___STROKE

___THYROID PROBLEM OTHER _____

FAMILY MEDICAL HISTORY _____

PAST SURGERIES: ___APPENDIX ___BREAST ____CANCER ____HERNIA ____ HYSTERECTOMY ____KNEE ____ THYROID ____TONSILS ____TUBAL OTHER _____

ALCOHOL USE: __NEVER __QUIT __SOCIAL ____ RARE ___DAILY _____DRINKS/DAY

CAFFEINE USE: ___NEVER __SELDOM ___DAILY _____CUPS/DAY

DRUG USE: ___NEVER __QUIT ___USE __MARIJUANA __COCAINE ___IV DRUGS

TOBACCO USE: __NEVER __QUIT __SOCIAL __DAILY _____PACKS/DAY_____YEARS

IF YOU ARE DIABETIC: Are you currently under a comprehensive Diabetic treatment plan? Y / N

LAST BLOOD SUGAR_____ **LAST A1C** _____ **DATE OF LAST PCP VISIT**_____

"I understand that insurance claims may be submitted to my insurance carrier on my behalf, however, I accept full financial responsibility for these claims regardless of my insurance company actions."

_____ _____

(Date) (Patient or Guardian Signature)

MEDICARE

_____ _____

(Name of Beneficiary) (Health Insurance Claim No.)

"I request that payment of authorized Medicare benefits be made either to me or on my behalf to Rodney M. Kosanovich, D.P.M. for any services furnished to me by that physician or 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 for related services."

MEDIGAP

_____ _____

(Name of Beneficiary) (Date)

_____ _____

(Beneficiary Signature) (Date)

"I request that payment of authorized Medigap benefits be made either to me or on my behalf to Rodney M. Kosanovich D.P.M. for any services furnished me by that physician/supplier. I authorize any holder of Medicare information about me to release to

_____

any information needed to determine these benefits payable for related services."

_____ _____

(Beneficiary Signature) (Date)

PRIVACY NOTIFICATION

I, _____, give permission to Dr. Kosanovich /Dr. Scanlan/Dr. Collings and associates to leave information on an answering machine. I understand this may pertain to medical information.

_____ _____

Signature Date

I also give permission for the following people to be given information, please circle all that apply

Spouse Mother Father Children Grandparents Other, please list names_____

MEDICAL RECORD POLICY

I/We understand that all of my medical information collected including office notes, lab testing, and x-rays are the property of Ankle and Foot Centers of Pittsburgh. I/We understand that I/We have the right to obtain a copy of all medical records in the possession of Ankle and Foot Centers of Pittsburgh in compliance with HIPAA regulations however, a written request must be presented to the office at least 5(five) days in advance of disbursement. Since we do not have the capabilities of copying x-rays, they will only be mailed directly to the medical office you have an appointment with. I/We also understand and agree to pay for all costs associated with copying the requested medical records prior to disbursement.

_____ _____ _____

Patient Name Signature Date