Welcome to the Office of David H. Eisenberg, DPM

PATIENT INFORMATION

Date:_____

Patient:_____
Last Name

_____
First Name Middle Initial

Address:_____

_____

City:_____ State:_____

Zip:_____ Birthdate:_____

Social Security #:_____

E-Mail:_____

Sex:___M ___F Age:_____ Single:_____

Married:_____ Divorced:_____ Widow:_____

Employer/School:_____

Address:_____

Spouse's Name:_____

Birthdate:_____

PHONE NUMBERS

Home Phone:_____

Work Phone: _____

Cell Phone:_____

Podiatric History

What is the chief complaint for which you came to be treated? _____

_____

_____

Have you ever been to a Podiatrist?

____Yes ____No If yes please list:

_____

_____

_____

INSURANCE

Insurance Co.:_____

ID #:_____

Group #:_____

Phone #:_____

Subscriber's Name: _____

Subscriber's Birthdate:_____

Relationship to Patient:_____

IN CASE OF EMERGENCY, CONTACT

Name:_____

Relationship:_____

Phone:_____

Podiatric History

Ankle Pain	___Yes ___No
Athlete's Foot	___Yes ___No
Bunions	___Yes ___No
Corns and Calluses	___Yes ___No
Flat Feet	___Yes ___No
Heel Pain	___Yes ___No
Ingrown Toenails	___Yes ___No
Injury to Foot or Ankle	___Yes ___No
Morton's Neuroma	___Yes ___No
Numbness in Feet or Legs	___Yes ___No
Orthotics	___Yes ___No
Plantar Warts	___Yes ___No
Swelling in Ankle or Feet	___Yes ___No

Alcohol: Daily Moderately Rarely None

Cigarette/Tobacco: Packs/Day_____ Years:_____

Past Smoker: Packs/Day_____ Years:_____

Consent

I certify that the above and attached information is true and correct to the best of my knowledge. I give authorization for the above listed patient to receive medical and/or surgical care and treatment with David H. Eisenberg, D.P.M.

Print Name:_____

Signature:_____
Parent/Guardian/Beneficiary

Date:_____

MEDICAL HISTORY

Place a Mark on "Yes" or "No" to indicate if you have had any of the following:

AIDS/HIV	___Yes ___No	Hepatitis or Jaundice	___Yes ___No
Allergies to Anesthetics	___Yes ___No	High Blood Pressure	___Yes ___No
Allergies to Medicine or Drugs	___Yes ___No	Kidney Problems	___Yes ___No
Anemia	___Yes ___No	Liver Disease	___Yes ___No
Angina	___Yes ___No	Low Blood Pressure	___Yes ___No
Arthritis	___Yes ___No	Neuropathy	___Yes ___No
Artificial Heart Valves or Joints	___Yes ___No	Phlebitis	___Yes ___No
Asthma	___Yes ___No	Psychiatric Care	___Yes ___No
Back Problems	___Yes ___No	Radiation Treatment	___Yes ___No
Bleeding Disorders	___Yes ___No	Rash	___Yes ___No
Cancer	___Yes ___No	Respiratory Disease	___Yes ___No
Chronic Diarrhea	___Yes ___No	Rheumatic Fever	___Yes ___No
Circulatory Problems	___Yes ___No	Shortness of Breath	___Yes ___No
Diabetes	___Yes ___No	Sinus Problems	___Yes ___No
Ear Problems	___Yes ___No	Special Diet	___Yes ___No
Epilepsy	___Yes ___No	Stroke	___Yes ___No
Eye Problems	___Yes ___No	Swollen Neck Glands	___Yes ___No
Fainting	___Yes ___No	Tuberculosis	___Yes ___No
Gout	___Yes ___No	Ulcers	___Yes ___No
Headaches	___Yes ___No	Varicose Veins	___Yes ___No
Heart Disease	___Yes ___No	Venereal Disease	___Yes ___No
Hemophilia	___Yes ___No	Weight Loss, Unexplained	___Yes ___No

Pain Level: Please check the number on the pain scale that best represents your level of pain at this time.

___0 ___1 ___2 ___3 ___4 ___5 ___6 ___7 ___8 ___9 ___10

(Zero: No Pain) (Ten: Worst Pain Possible)

Surgical History

_____

_____

_____

Height:_____ Weight:_____

Shoe Size:_____

Allergies

Adhesive Tape	___Yes ___No
Anticoagulant Therapy	___Yes ___No
Aspirin	___Yes ___No
Codeine	___Yes ___No
Demerol	___Yes ___No
Iodine	___Yes ___No
Local Anesthetics	___Yes ___No
Novocaine	___Yes ___No
Penicillin	___Yes ___No
Seafood	___Yes ___No
Sulfa	___Yes ___No

Other:_____

Hospitalization

_____

_____

Medications

_____

_____

_____

_____

_____

Pharmacy Name:_____

Pharmacy Phone:( ) _____

Family Physician:_____

Physician Phone:_____

Date of Last Visit:_____

Whom may we thank for referring you to our office?_____

David H. Eisenberg, D.P.M.

Due to the over whelming number of insurance plans, it is impossible for our front desk staff to guarantee any coverage by any individual insurance plan. Everyone's insurance is different-even those with same employer and insurance company! Each patient is responsible for knowing their own insurance coverage including the deductible and coinsurance and the amount met, the copay amount, and the coverage policies for procedures. Each patient is also responsible for obtaining their referral and knowing the number of visits, the effective date and the expiration date of that referral. Or office attempts to verify each patient's insurance benefits with your insurance company prior to their visit. At check out, each patient is charged according to the insurance benefit information and fee schedules that we receive from their insurance company. Once the insurance claim has been processed an explanation of benefits (EOB) is received, a bill or a credit will be issued if necessary. Most insurance companies require the payment of a deductible for any in-office procedure. All deductible charges and co-payments must be paid at the time of service is rendered. If you are unable to comply with this policy, please notify the front desk staff and appropriate measures will be taken. David H. Eisenberg, D.P.M is a specialist office and as defined by the insurance companies, is not a primary care provider (PCP). The fee schedule for each procedure has been predetermined by each participating insurance company by contract with Dr. Eisenberg. We will file all claims to your insurance.

I understand and agree that I am ultimately responsible for meeting my obligation of the balance of my account for any professional services rendered to myself and /or my dependents. I agree to obtain a referral from my primary care physician if this is required by my insurance company. I understand that I am ultimately responsible for knowing the specifics of my insurance plan copays, deductible, and excluded treatments. In the event this office files medical insurance on my behalf, I authorize the release of medical information necessary to process claims. I also authorize payment of medical benefits to the Doctor for services provided. A photocopy of this assignment is as valid as an original. I understand that I am financially responsible for all charges whether or not they are paid by my insurance. I **agree to pay any deductible or copay required by my insurance company for that day's charges at the time of check out.** My account will be charged $35 for any returned checks.

This summary is provided to assist you in understanding the following Notice of Privacy Practices.

Uses and Disclosures of Health Information we will use and disclose your health information in order to treat you or to assist other health care providers in treating you. We will also use and disclose your health information in order to obtain payment for your services or to allow insurance companies to process insurance claims for services rendered to you by us and other health care providers.

Uses and Disclosures Based on Your Authorization except as stated in more detail in the Notice of Privacy Practices, we will not use or disclose your health information without your written authorization. For a full description of Notice of Privacy Practices, contact Dr. Eisenberg's office administrator.

I hereby consent and give my permission to Dr. David H. Eisenberg (and the doctor's assistants or designated replacement) to administer and perform such procedures upon me as the doctor deems necessary.

_____ _____

Signature of Patient, Parent, Guardian, or Personal Representative | Date

_____ _____

Please Print name of Patient, Parent, Guardian, or Personal Representative | Relationship to Patient

HIPAA AUTHORIZATION FORM

Patient's Full Name	**Patient's Social Security Number/Medical Record Number**
Address	**Patient's Date of Birth**
City, State Zip Code	**Patient's Telephone Number**

I hereby authorize use or disclosure of protected health information about me as described below.

1. The following person(s) may receive disclosure of protected health information about me:

   Name/ Relationship

   Name/ Relationship

   Name/ Relationship

2. The specific information that should be disclosed is (Please circle ALL that apply) :

   Appointment information Medical information (Diagnosis/ Treatment Plan) Billing information

UNLESS YOU SIGN HERE, NO INFORMATION ABOUT ALCOHOL/SUBSTANCE ABUSE, HIV/AIDS, OR MENTAL HEALTH WILL BE DISCLOSED:
YES, DISCLOSE THIS INFORMATION *_____

NO, **DO NOT** DISCLOSE THIS INFORMATION * _____

Signature of Individual*	**Date of Individual's Signature**	**Date of Birth or Social Security Number**

OR, if applicable –

Signature of Guardian* or Personal Representative of Patient's Estate	**Date of Guardian's/Personal Representative's Signature**	**Description of Authority to Act for the Individual**

Please initial on either YES or NO line if you would like a copy of this form:

YES _____ NO _____

Official Use Only

Processed By	**Date**	**Time**