Daniel L Altchuler, DPM
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WELCOME TO OUR OFFICE

Patient____ Date_____/_____/_____
Home Address__________________________________ Apt/PO Box______________
City____________________________________ State_________ Zip ___________
Home Phone # (_____)_______________ Cell Phone # (_____)_________________
Work Phone # (_____)_______________ Ext _____ E-Mail: ____________________
Social Security #: ______________________________ Dr Lic #__________________
Date of Birth_____/_____/______ Age_______ Sex: Male ___ Female ___
Marital Status: Single ___ Married ___ Widowed ___ Separated ___ Divorced ___
Spouse's/Guardian's Name____
Spouse's Date of Birth_____/_____/______ Social Security #: ___________________

Patient Employer

Employer______________________________________ Occupation______________
Employer Address____
City____________________________________ State_________ Zip ___________
Employer Phone # (_____)___________________ Contact Person________________

Spouse Employer

Employer______________________________________ Occupation______________
Employer Address____
City____________________________________ State_________ Zip ___________
Employer Phone # (_____)___________________ Contact Person________________

Insurance Information

Who is responsible for this account? Patient ____ Other: ______________________
Relationship to Patient? ____
Primary Insurance Company ____
Group/ID # ______________________________ Plan # ________________________
Are you covered by another insurance? Yes ____ No ____
Subscriber's Name____

Race____

Ethnicicty____

No answer____

Subscriber's Date of Birth_____/_____/_____ Subscriber's SS #_________________

Relationship to Patient? ____

#2 Insurance Company ____

Group/ID # ______________________________ Plan # ___________________

Are you covered by another insurance? Yes ____ No ____

Subscriber's Name____

Subscriber's Date of Birth_____/_____/_____ Subscriber's SS #_________________

Relationship to Patient? ____

#3 Insurance Company ____

Group/ID # ______________________________ Plan # ___________________

Primary Care Provider

Who is your primary care provider?_____________________________________

What was the date of your last visit?____

Address of Primary Care Provider_______________________________________

Telephone____

Assignment of Benefits & Authorization to Release Information to My Insurance Company

I, the undersigned certify that I (or my dependent) have insurance coverage with the above plan(s), and hereby assign all insurance benefits, if any, otherwise payable to me, directly to Daniel L. Altchuler, DPM/Noah A. Blumofe, DPM/Robert Portillo, DPM/Mary T. Schuh, DPM/Eileen L. Haworth, DC for services rendered. I understand that I am financially responsible for all charges whether or not paid by my insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits from my insurance company(ies).

I authorize the use of my signature below to reflect my agreement and authorization for the above for all insurance submissions.

Responsible Party Signature____

Relationship__________________________________ Date_____/_____/_____

Medicare Authorization

I, the undersigned, request that payment of authorized Medicare benefits be made on my behalf directly to Daniel L. Altchuler, DPM/Noah A. Blumofe, DPM/Robert Portillo, DPM/Mary T. Schuh, DPM/ Eileen L. Haworth, DC for services rendered. I hereby authorize the doctor to release to the Centers of Medicare and Medicaid Services (CMS) all information necessary 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 Section 9 of the HCFA 1500 claim 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, copayment, and charges associated with non-covered services. Copayments and deductibles are based upon the charge determination of the Medicare carrier.

Beneficiary Signature____________________________________Date_____/_____/____

How Did You Find Us? Whom Can We Thank? ____________________________________

[Please Print CLEARLY]

Who is your Primary Care Physician? ______________________

Who can we thank for referring you to us? ______________________

History & Medical Information

1. **Explain your foot/ankle problem** ☐ Right ☐ Left ______________________

2. **When did pain/discomfort begin (date):** ______________________
   Describe pain/discomfort: ☐ Burning ☐ Numbness ☐ Sharp ☐ Other ______________________
3. **What makes the pain/discomfort better:** ______________________
4. **Have you had a physical trauma?** ☐ No ☐ Yes ______________________
5. **Have you had an accident?** ☐ No ☐ Yes ______________________
6. **Occupation:** ______________________ **Is your problem work related?** ☐ Yes ☐ No
7. **Past Medical History:**

☐ Anemia	☐ Gout	☐ Kidney Disease	☐ Osteoarthritis
☐ Bleeding Disorders	☐ Heart failure	☐ Lung/Respiratory Disorders	☐ Other Arthritis
☐ Cancer ____________	☐ Hepatitis	☐ Mitral Valve Prolapse	☐ Rheumatic Fever
☐ Diabetes	☐ High Cholesterol	☐ Nerve Disorders	☐ Stroke
☐ Epilepsy	☐ HIV / AIDS	☐ Neurological Disorders	☐ Thyroid Disorders
	☐ High Blood Pressure	☐ Prostate Disorders	☐ Other: ___________

8. **List all medications/herbs/vitamins:** ☐ **NONE** ______________________

9. **Allergies:** (Describe reaction) ☐ **NONE**
   ☐ Penicillin ____________ ☐ Aspirin ____________ ☐ Narcotic Agent / Codeine ____________
   ☐ Anesthesia ____________ ☐ Shellfish ____________ ☐ Sulfa Drugs ____________
   ☐ Nickel / Metal ____________ ☐ Radiographic Contrast Dye ____________
   ☐ Other ______________________
10. **Are you currently pregnant?** ☐ No ☐ Yes ______________________
11. **Surgical History:** Have you had surgery? ☐ Yes—if yes, describe below ☐ No
    Surgery / Date: ______________________

12. **Social History:** (Only check what is pertinent to you)
    ☐ Tobacco Use ☐ Alcohol Use ☐ Exercise habits______________________
    ☐ Caffeine Use ☐ Drug use (recreational, IV)
13. **Family History: (List relationship of family member(s) who have had these problems):**
    ☐ Diabetes____________ ☐ Heart Disease ____________ ☐ Kidney Disease ____________
    ☐ Hypertension ____________ ☐ Stroke ____________ ☐ Mental Illness ____________
    ☐ Rheumatology ____________ ☐ Bleeding Disorders ____________ ☐ Cancer ____________
    ☐ Other family History: ______________________
14. **Shoe size:** ____________

Patient Name: ______________________________ Date: _____________

Review of Systems

Please check any of the following that you are **currently experiencing** or have **recently experienced.**

Constitutional			
☐ Fever	☐ Chills	☐ Sweats	☐ Weight Change
Head, Eyes, Ears, Nose and Throat			
☐ Wear Contact Lenses	☐ Dentures	☐ Wearing Eyeglasses	
☐ Double Vision	☐ Cataract	☐ Dizziness	
☐ Difficulty Swallowing	☐ Neck Pain	☐ Sore Throat	
☐ Nosebleeds	☐ Problems with eyesight	☐ Ringing in the Ears	
Cardiovascular			
☐ Chest Pain / Discomfort	☐ Cardiovascular Symptom	☐ Heart Murmur	
☐ Swelling lower extremity	☐ Leg Pain with Exercise	☐ Palpitations	
Hematologic/Lymphatic			
☐ Bleeding Problem	☐ Swollen Glands	☐ Lymphoma	
☐ Anemia	☐ Skin Lump - Location		
Respiratory			
☐ Difficulty Breathing	☐ Wheezing	☐ Previous Pulmonary Disease	
☐ Exposure to TB	☐ Cough	☐ Pulmonary Symptoms	
Gastrointestinal			
☐ Nausea	☐ Vomiting	☐ Diarrhea	
☐ Decrease in Appetite	☐ Abdominal Pain	☐ Constipation	
Endocrine			
☐ Often Thirsty	☐ Frequent Urination	☐ Thyroid Disease	
☐ Urinary Symptoms	☐ Prostate Problems	☐ Prior Kidney Disease	
Musculoskeletal			
☐ Musculoskeletal symptoms	☐ Feeling weak	☐ Join Pain, Arthralgia	
☐ Weakness of limbs	☐ Prior Fracture		
Nervous System			
☐ Ataxia	☐ Speech Difficulties	☐ Headache	
☐ Neuropathy	☐ Confusion/ Disorientation	☐ Fainting	
☐ Convulsions			
Skin			
☐ Rash	☐ Ulcer	☐ Lesions	☐ Sun Sensitivity
☐ Color Change	☐ Slow Healing	☐ Infections	☐ Cracking
☐ Eczema (Pruritus)	☐ Growth	☐ Hair Loss	
Allergic, Immunologic History			
☐ Dermatitis	☐ Rheumatoid Arthritis	☐ Lupus	☐ Collagen Vascular
Psychiatric			
☐ Nervousness	☐ Tension	☐ Depression	