WILLIAMSBURGFOOTCARE.COM

STEVEN L. BARKOFF, DPM

BOARD CERTIFIED FOOT SPECIALIST

PATIENT INFORMATION

Patient's Name**:** _____ **Today's Date:**_____

Address**:** _____

APT#

City/State/ZIP: _____

Email: _____ Marital Status: _____

Home Phone: (___)_____ Work Phone: (___)_____ Cel Phone: (___)_____	**Date of Birth**: _____/____/_____ Age:_____ **Social Security #:** _____ Sex: ☐ Male ☐ Female

Place of Employment _____

Employment **Address:**_____

_____

Work Telephone#:_____**EXT:**_____

If not working are you a student?: ☐ No ☐Yes, → if Yes ☐Full Time Student ☐ Part Time student

Family Physician: Approximate **Date** you last saw you Primary Care Doctor? _____

Dr's Name: _____ Phone #: ( )_____

Dr's Address: _____City/State/Zip_____

HEALTH INSURANCE INFORMATION

Primary Insurance:_____

_____

Secondary Insurance:_____

☐ **Flexible Spending**

How did you learn about our office? (Please give names & check all that apply)

☐ Friend _____ ☐ Yellow pages ☐ Internet

☐ Doctor _____ ☐ Newspaper _____ ☐ Other_____

Have you had Previous PODIATRY CARE? ☐ **Yes** ☐ **No**

if yes, Dr's Name _____ Date _____

Treatment _____

_____

Steven L. Barkoff, D.P.M.

Williamsburg FootCare.com

ASSIGNMENT OF BENEFITS

FOR MEDICARE PATIENTS ONLY: **YEAR 2011 DEDUCTIBLE is $155.00**
Please note when the Doctor is taking ASSIGNMENT, it means that you are responsible for **yearly deductible** and for the **20% (Co-Insurance)** of what Medicare allows. If you have co-insurance, you are also responsible for services that your co-insurance doesn't cover.

Unlike some offices, the FILING OF INSURANCE CLAIMS is a COURTESY that we have always extended to our patients. However, all charges are YOUR responsibility, NOT YOUR Insurance Company's. We will make our BEST EFFORT to collect from them, but if, despite our best efforts, we are NOT SUCCESSFUL, YOU are responsible for the unpaid balance.

We realize that temporary financial problems may affect timely payment of your account. We don't want any financial problems to get in the way of our good relationship with you. If such problems arise, we encourage you to contact us promptly for assistance in the management of your account.

C O N S E N T

I give permission to the doctor and associates or affiliates to administer and perform such procedures as may be deemed necessary in the diagnosis and/or treatment of my feet.

SIGNATURE ON FILE

1. **I authorize use of this form on *all* my insurance submissions**
2. **I authorize release of information to all my *insurance companies***
3. **I understand that *I am responsible* for my bill**
4. **I authorize my doctor to act as *my* agent in helping me obtain payment from my insurance companies**
5. **I authorize payment direct to my doctor**
6. **I permit a copy of this authorization to be used in place of the original**

NAME _____ **INSURANCE ID NO.:** _____
PLEASE PRINT

SIGNATURE_____ **DATE** _____

Notice of Privacy Practices

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read if I so choose) and understood the Notice.

_____ _____
Signature Date

NAME: _____ ☐ F ☐ M **D/O/B:** ___/____/____

YOUR HEALTH HISTORY

1. Do you have any of the following medical conditions: (check all that apply)

☐ Arthritis	☐ Heart Disease	☐ Psychological
☐ Asthma	☐ High Blood Pressure	☐ Stroke
☐ Diabetes	☐ Kidney Problems	☐ Respiratory
☐ Epilepsy	☐ Hypercholesterolemia	☐ Cancer
☐ Liver Disease	☐ Gastrointestinal Problems	☐ Heart Attacks

☐ Other: _____

3. ALLERGIES:

☐ Penicillin	☐ Codeine	☐ Other: _____
☐ Sulfa Drugs	☐ Iodine/ Shellfish	_____
☐ Local Anaesthetics	☐ Tape	
☐ Aspirin	☐ Antibiotics	

4. DO YOU USE:

☐ CIGARETTES/TOBACCO
☐ ALCOHOL
☐ ILLEGAL DRUGS

5. Is there a family history of?

☐ DIABETES	☐ KIDNEY	☐ SICKLE CELL
☐ CANCER	☐ HEART PROBLEM	☐ Foot Problems

☐ Other_____

6. WHAT MEDICATIONS DO YOU CURRENTLY TAKE?

_____

_____

7. HAVE YOU EVER HAD SURGERY? ☐ NO ☐ YES
IF YES, DATE AND TYPE OF SURGERY: _____

8. Have you ever been hospitalized? ☐ NO ☐ YES - if yes, when? _____

Reason: _____

_____

9. **Foot Complaint/s:** _____

_____