TOTAL FOOT CARE

Dr. Richard S. Cohen
Dr. Jeffrey E. Steinberg

7525 Greenway Center Dr. #112
Greenbelt, MD 20770

Phone 301-345-4087 *Fax 301-345-0482*

PATIENT'S MEDICAL INFORMATION

Patient's Name: _____

Primary Physician's Name: _____ Date of last exam: _____

Physician's Address: _____ Reason for last treatment: _____

_____ _____

Physician's Phone: _____ **Health**: Good ☐ Fair ☐ Poor ☐

Medications: dosage and how often you take them: _____

_____ None ☐

Operations/Serious Illness: Yes ☐ No Please give details: _____

_____

Have you ever been treated for substance **abuse**? Alcohol ☐ Drugs ☐ None ☐

Do you **drink**? Yes☐ No☐ How much? _____ Do you **smoke**? Yes No How much?_____

Have you experienced any unusual or allergic **reactions** to: Penicillin ☐ Aspirin ☐ Sulfa ☐

Codeine ☐ Novocain/Xylocaine ☐ Iodine ☐ Tape ☐ Foods ☐ None ☐

Other ☐ _____

Please **CIRCLE** if you have ever had or now have:

Diabetes-- Cancer-- Thyroid Problems-- Respiratory Problems/Asthma-- HIV positive/AIDS--

High Blood Pressure-- Heart Problems-- Hepatitis-- Tuberculosis-- Epilepsy--

Gout-- Arthritis-- High Cholesterol-- Venereal Disease/STD-- Difficulty in Healing--

Acid Reflux-- Stomach Ulcer-- Phlebitis-- Blood Clots-- Bad Circulation--

Skin Problems-- Nervous Condition-- Depression-- Numbness to Feet or Legs--

What is you current foot/ankle **problem**?

_____

I certify that the above information is true to the best of my knowledge. I further understand that it will not be given out and it is confidential. I agree to allow the doctor to examine me and understand treatments will be explained to me before they are started.

Patient's Signature: _____ **Date**: _____

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Drs. Cohen and Sassoon and staff would like to welcome you to our office. Please help us to better serve you by answering the following questions. All information is confidential and important for our files and your health.

Patient's Name: _____ Birthdate: _____ Age: _____
Address: _____ Marital Status: S M D W SEP Sex: M F
_____ Height: ____ Weight: ____ Shoe Size: ____
Occupation: _____ Home Phone: _____
Employer: _____ Work Phone: _____
Social Security #: _____ Cell Phone: _____
E-mail: _____

REFERRAL: How did you hear about our office?

_____

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FINANCIAL INFORMATION, POLICY & AUTHORIZATION

Primary Insurance Company: _____
Subscriber's Name: _____ Subscriber's Date of Birth: _____

Relationship to Subscriber: Self ☐ Spouse ☐ Child ☐ Other ☐ _____

Secondary Insurance Company: _____
Subscriber's Name: _____ Subscriber's Date of Birth: _____

Relationship to Subscriber: Self ☐ Spouse ☐ Child ☐ Other ☐ _____

AUTHORIZATION

I hereby authorize Richard S. Cohen, D.P.M., P.A. and Jeffrey E. Steinberg, D.P.M. to apply for benefits on my behalf for covered services rendered by Drs. Cohen and Steinberg. I request payment from my insurance carrier to be made directly to Richard S. Cohen, D.P.M, P.A. I certify that the information I have reported with regard to my insurance coverage is correct and further authorize the release of any necessary information, including medical information, for this or any related claim to my insurance carrier. I permit a copy of this authorization to be used in place of the original. This authorization may be revoked by me at any time in writing. It is my understanding that all unpaid charges by my insurance carrier are my responsibility and I agree to pay them. It is also my understanding that a $5.00 billing fee per month will be charged to my account on all unpaid charges over 30 days. I further understand that any fees incurred involving collection of my past due account will be paid by me.

_____ _____

Signature of Subscriber or Beneficiary **Date**